DOCUMENT RESUME

ED 311 675	EC 221 093

TITLE	Child Abuse and Neglect: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services. A Report to the 71st Legislature.
INSTITUTION	Texas State Dept. of Human Services, Austin.; Texas State Dept. of Mental Health and Mental Retardation, Austin.
PUB DATE	1 Jan 89
NOTE	126p.; Prepared by the Joint Study Committee on Treatment of Child Abuse.
PUB TYPE	Reports - Descriptive (141) -- Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Agency Cooperation; *Child Abuse; *Child Neglect; *Cost Effectiveness; Delinquency; *Delivery Systems; Family Problems; *Incidence; *Needs Assessment; Program Costs; Recordkeeping; Research Needs; School Role; State Programs; Therapy
IDENTIFIERS	*Texas

ABSTRACT

The report provides a comprehensive review of child abuse and neglect concerns in Texas and offers a variety of recommendations. Data on the extent of the problem indicate that the need for treatment services has outstripped available resources. The direct and indirect costs of untreated child abuse are estimated. The joint study committee examined a variety of treatment models and concluded that intensive family-based services provide effective treatment at lower costs than traditional approaches. Other conclusions were that delivery of treatment services should incorporate a continuum of services which includes prevention, should draw upon existing state and local resources, and should employ a combination of treatment methods; and that not providing treatment ultimately costs society much more than the treatment costs. Treatment service gaps were identified and included a lack of interagency coordination, no uniform method of identifying and tracking child abuse and neglect victims, and the lack of resources to adequately treat all abused children. Eleven major recommendations address creation of an interagency council, research and data collection, funding, priority system for treatment, joint training, residential treatment, a family-based services project, a school-based therapy project, and treatment for juvenile perpetrators. Ten appendixes provide further detail on psychiatric problems associated with child abuse, costs, and treatment, and include a copy of the Oregon model for a continuum of services, a history of Texas state agency involvement in child abuse issues, an American Bar Association report on corporal punishment, and a proposal for school-based therapy. (DB)

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CHILD ABUSE AND NEGLECT: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services

A Report to the 71st Legislature

Prepared by
Joint Study Committee
on Treatment of Child Abuse

January 1, 1989

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Executive Summary

CHILD ABUSE AND NEGLECT: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services

EXTENT OF THE PROBLEM

In the field of child abuse treatment Texas faces a major dilemma, which is growing with each budget consideration. The number of abused children in Texas who need treatment is significantly greater than the resources for providing basic treatment services, even though spending for these services has increased over the past decade.

During 1987, 108,090 Texas children were alleged victims of child abuse and neglect; of those, 57,067 were confirmed victims under the Texas Family Code. This reported incidence of child abuse and neglect is 22 per thousand, in line with national estimates ranging from 12 to 35 per thousand.

Child abuse and neglect is estimated to be even more extensive than these statistics indicate. It was estimated that over 427,000 Texas children were at risk of abuse or neglect in FY '88. This estimate is consistent with estimates from the National Center on Child Abuse and Neglect, which suggest that 66 percent to 87 percent of child abuse cases nationwide are not reported.

Victims of child abuse and neglect suffer physical, emotional, and behavioral effects. Maltreated children exhibit chronic health problems, poor school performance, learning disabilities, cognitive and language disorders, poor emotional health, and difficulties in relationships. Delinquent and deviant behavioral patterns are common.

Untreated victims may never heal or become fully productive members of society. Adults who were mistreated as children are likely to be substance abusers, engage in criminal behavior, or have recurring mental and physical health problems. For example, a study of inmates in the Ferguson Unit of the Texas Department of Corrections (TDC) demonstrated that 65 percent had been abused as children.

The need for treatment services has outstripped available resources. By the end of FY '89, the Texas Department of Human Services (TDHS) will provide in-home services to 60 percent of the families in which abuse or neglect is confirmed. However, only about 20 percent of Texas children whose cases of abuse or neglect were considered "founded" receive needed individual or group therapy. An even smaller percentage of all Texas children actually abused receive services from mental health providers.

THE EFFECTS OF UNTREATED CHILD ABUSE

Maltreated children suffer physical and emotional damages. The effects of maltreatment tend to be severe and long-term. Such children require treatment through intervention by social service agencies, special education programs, mental health providers, or juvenile and criminal justice systems.

Untreated children later come into state agency systems as emotionally disturbed or delinquent minors or as adults who are dysfunctional, criminal, or dependent upon other social services. Lack of early treatment intervention results in progressively more costly demands on state funding as the untreated abused child lives out a life dependent upon state social, mental health, special education, and correctional services.

Direct Costs. Child abuse imposes direct costs. Most abuse and neglect victims require community-based services (including institutional care) through mental health, educational, child protective, or juvenile justice systems. The Texas state agencies that contributed to this report recognize that many of their clients would not have come to agency attention in the first place if they had not been victims of abuse or neglect.

Texas spends an average of over $23,000 each year to maintain one child in facilities of the Texas Youth Commission (TYC). In FY '88, TYC served an average daily population of over 3,800 children. Half of these children were served in residential programs at a cost of $64 per day or over $44 million in FY '88.

The Texas Department of Human Services (TDHS) confirmed 44,694 abuse and neglect victims in FY '88. To further illustrate the enormous costs of child abuse, consider only the 13,230 confirmed by TDHS as being physically abused. If only half this number require hospitalization for five days each, the medical costs would exceed $10 million. If 25 percent require special education services, the educational costs to the state for one year would be $17 million. If only 1 percent suffered permanent developmental disabilities, the cost of community services would be an additional $0.5 million each year. Increased rates of substance abuse, emotional problems, and family disruption also result in substantial direct costs to service agencies.

(The cost estimates in the preceding paragraph are not actual costs incurred by state agencies. They are estimates for treating the consequences of physical abuse and only partially illustrate the continual costs of providing services to children who are abused and neglected.)

Indirect Costs. The indirect costs that result from lack of treatment are great. There is overwhelming evidence that victims of child abuse and neglect often fail to become productive members of society. Eventually many victims of child abuse end up in one social service system or another. As adults, abused and neglected children are more likely to be in public assistance programs, to have employment difficulties, to have mental health problems, and to overuse health care systems.

To partially illustrate these indirect costs, the committee examined the cost of maintaining inmates in the Texas Department of Corrections (TDC). In FY '87, TDC had an average daily population of over 39,000, and the cost for maintaining one inmate for one year was over $15,000. Considering that the average length of stay in TDC is 17 months and the recidivism rate within two years of release is 30 percent, significant costs accrue for maintaining a person in TDC. Assuming that about 65 percent or 25,000 of these inmates had been abused as children, child abuse contributed significantly to these TDC costs. This amount does not include the cost of services to those under TDC supervision in FY '87.

SERVICE AND TREATMENT NEEDS OF CHILD ABUSE VICTIMS

What can be done to ensure that abused and neglected children in Texas receive effective treatment so that they may develop into self-sufficient, productive citizens?

Mandate of the Joint Committee. In Senate Bill 257 the 70th Texas Legislature mandated the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Department of Human Services (TDHS) to conduct a joint study of current methods for treating abused children, the effectiveness of each method, and the feasibility of using the methods in Texas. The study was to consider fiscal impact and any necessary statutory changes and be submitted to the appropriate committees of the house and senate by January 1, 1989.

Committee Composition. Due to the extent and complexity of the problem of child abuse and the inherent need for a multi-systems approach to address the issues that affect the cycle of abuse, it was decided that the joint study group should include other state agencies that also serve this population of children. The Texas Youth Commission (TYC), Texas Education Agency (TEA), and the Texas Juvenile Probation Commission (TJPC), as well as representatives from the private sector, joined TDMHMR and TDHS in the study.

Study Findings—Treatment Models. The Joint Study Committee reviewed current methods for treating abused children. The following methods were identified: clinic-based therapy, residential-based therapy, therapeutic day treatment, support group therapy, and intensive family-based services. Each method has two components—a therapeutic treatment and a system through which the service is delivered.

The committee found that the therapeutic approach in intensive family-based services provides an effective treatment method at costs substantially less than traditional approaches examined. These home-based services can be cost-effectively provided in Texas in the immediate future. Oregon has a program that demonstrates a net savings to protective services through the use of home-based treatment programs.

The Joint Study Committee examined models for delivery of treatment services and concluded that a model for Texas should—

- incorporate a *continuum of services* that includes prevention as well as treatment;
- draw upon existing state and local resources in order to (a) reduce duplication and costs and (b) produce the most comprehensive and effective treatment of abused children;
- provide for analysis of administrative and resource issues; and
- employ a combination of treatment methods.

The State of Oregon has developed and implemented a system based on such a model. Protective services and treatment activities are coordinated between the human services and mental health departments. Included in this service continuum are a Family Sexual Abuse Treatment Program; a High-Risk Infant Treatment Program; a Victim Treatment Group; Non-Offending Spouse Treatment; and Intensive Family Services. The Oregon system also includes an extensive treatment program for juvenile sexual offenders. The treatment continuum provides community-based services as well as residential care. A continuum-of-services model such as that demonstrated in Oregon should be examined for use in Texas.

Study Findings—Cost-Effectiveness. Findings suggest that the costs associated with primary and direct treatment efforts, including home-based services, respite care, and therapy, are well worth their initial expense. Not to provide these services ultimately costs society much more (National Council of Juvenile and Family Court Judges, 1986; Daro, 1988).

Effective treatment of child abuse can be provided through home-based services. Other treatment programs such as school-based therapy, a method that provides a cost-effective system for reaching abused children, can be provided at a cost of $300 to $900 per child per year (see Appendix J).

GAPS IN TREATMENT SERVICES

The most cost-effective delivery system would coordinate existing service delivery mechanisms. (This finding is supported by a draft report for the 71st Legislature being prepared by the Health and Human Services Coordinating Council on its study of reorganizing services to children and youth.)

The Joint Study Commitee on Child Abuse describes resources for treating child abuse and neglect that are now available from five agencies —TDMHMR, TDHS, TYC, TEA, and TJPC (Section 4). In addition, Appendix A describes a continuum-of- services model program for treatment of child abuse and neglect, and Appendix B describes services currently available, private as well as public, in Travis County.

Many of the mechanisms and programs necessary for the implementation of the continuum-of-services model proposed by this committee are in place. However, the following large gaps in services remain:

- There is a lack of interagency coordination in providing treatment services.
- There is no uniform method of identifying and tracking child abuse and neglect victims served by various state agencies.
- The need for treatment services has outstripped the available resources. Therefore, the majority of children who need treatment services do not receive them.
- Resources to treat all abused children in need of service are not available due to funding limitations. Many of the needed treatment programs are offered but are not available statewide.
- Lack of resources for treatment of child abuse dictates that most services be concentrated on the most immediate and threatening situations.

- Only limited services are available for juvenile perpetrators of abuse.
- Texas already has court-ordered parental responsibility for approximately 12,500 children at any one time (an average of 8,700 in TDHS conservatorship and 3,800 under TYC custody). These children and their families need treatment to help them avoid future dependence on public services.
- Personnel from the five agencies working directly with children need training on recognizing, reporting, assessing, and diagnosing abuse and neglect, as well as alternative medical and psychosocial treatments.

RECOMMENDATIONS

To begin addressing the wide gaps in the delivery of services, the Joint Study Committee makes the following recommendations.

Recommendation 1—Interagency Council. It is recommended that all of the agencies working with Texas children (i.e., TDHS, TDMHMR, TYC, TEA, and TJPC) create an Interagency Council on Child Abuse to coordinate research funding and programming for abused and neglected children.

Recommendation 2—Research. It is recommended that the five state agencies working with abused children conduct research on the identification and treatment of abused and neglected children in Texas. The Interagency Council on Child Abuse will direct and expand the research efforts including, but not limited to, the issues addressed in recommendations 2a through 2e.

Recommendation 2a—Data Collection. It is recommended that effective September 1, 1989, state agencies will begin to develop a system for collecting demographic data on children served who have been abused and neglected as defined by TDHS's management information system and corresponding data elements, with full implementation of the data collection process by January 1, 1990. In order to conduct research on the problem of child abuse and neglect, it is essential to know more about the demographics of the abused population currently served by the five state agencies.

Recommendation 2b—Sharing Information. It is recommended that state agencies have a clearinghouse on information about any new child in their system.

There will be no restrictions prohibiting one state agency from sharing information on abuse and neglect with another state agency serving the same child, except where legal considerations preclude divulging names. In such cases, agencies such as TJPC will collect data that specify the number of children referred and adjudicated that have been identified as abuse or neglect victims.

Recommendation 2c—Common Definitions and Formats. It is recommended that all state agencies use the same criteria and format for collecting demographic information on abused and neglected children in the state.

When a child is identified as having been abused or neglected, according to the Texas Family Code, this information should follow the child when she/he moves from one state agency to another. The sharing of information by all state agencies will minimize duplicate data collection and enhance efforts to coordinate services to children across agencies.

Recommendation 2d—Evaluation of Therapeutic Outcomes. It is recommended that one of the first efforts of the Interagency Council will be to conduct a research project in Texas to determine the effectiveness of various therapies for treating child abuse.

Recommendation 2e—Examination of Service-Delivery Model. It is recommended that a model for delivery of rehabilitative, community-based services such as the Oregon system be examined as a model for use in Texas.

The state of Oregon has implemented a system by which human services and mental health departments coordinate protective and treatment services.

Recommendation 3—Funding for Interagency Programs. It is recommended that additional and adequate funds be provided to each agency to support interagency programs for abused and neglected children.

A network is essential to serve children who have been abused. Although each agency has distinct service areas, the abused and neglected children are a shared population whose needs are not being effectively served

Recommendation 4—Priority System for Treatment. It is recommended that the Interagency Council on Child Abuse establish a system for deciding which children should receive the treatment services that state agencies' limited resources permit.

The system should consider factors such as the large number of children already in the custody or conservatorship of the state, the severity of the abuse victims' need as judged clinically, and the identification of high-risk indicators in the child's current situation.

Recommendation 5—Joint Training. It is recommended that joint agency training on child abuse and neglect issues be instituted.

Recommendation 6—Corporal Punishment. It is recommended that further study be conducted to review the effects of corporal punishment on children, especially children who have been physically abused.

Physical force of any kind is abusive. Using physical punishment negates any therapeutic progress that may be made in the treatment of abused children. Non-aversive behavior management techniques can be used when disciplining children. It is especially important that these techniques be used with abused and neglected children in order to prevent further trauma and to augment treatment.

Recommendation 7—Residential Treatment for Children in State Conservatorship. It is recommended that a study be conducted addressing the problem of children in state conservatorship who need in-patient or other residential treatment. Current law requires court commitment or consent by the child. In many instances, children who do not meet commitment criteria and refuse treatment are nevertheless in need of treatment services.

Recommendation 8—Family-based Services Project. It is recommended that funding be provided to TDMHMR, TDHS, TYC, and TJPC for the development and implementation of joint pilot projects on intensive family-based services at selected sites in Texas.

Intensive family-based services provide an alternative to the extensive use of substitute care for abused and neglected children. These programs have reported a high success rate at costs significantly lower than foster homes and institutional care. They also avoid the social and psychological trauma created when a child is placed outside the home.

Recommendation 9—School-based Therapy Project. It is recommended that funding be provided to develop school-based therapy groups for abused children in elementary and secondary schools, with the intent of later implementing the program statewide.

Most abused children never receive counseling. School-based therapy provides a cost-effective mechanism for reaching abused children.

Recommendation 10—Treatment for Juvenile Perpetrators. It is recommended that the 71st Legislature support the Sex Offender Council's report, which suggests that TYC's Sex Offender Treatment Programs be expanded, and it is recommended that the TJPC Challenge Grant Program be expanded and funds increased to assure placement of juvenile perpetrators in community-based treatment programs.

Recommendation 11—Responsibility for Juvenile Perpetrators. It is recommended that further study be conducted on assigning responsibility for services to juvenile perpetrators of child abuse and neglect.

Recommendations 10 and 11 address the need to stop the cycle of abuse. As part of a comprehensive approach to confronting child abuse, services need to be implemented that aim directly at abused children who in turn become abusers.

1

Introduction

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MANDATE OF THE JOINT COMMITTEE

Senate Bill 257, Section 2.37, 70th Texas Legislature, Regular Session, 1987, directed the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Department of Human Services (TDHS) to "conduct a joint study of current methods for treating abused children, the effectiveness of each method, and the feasibility of utilizing the methods in this state. The study shall consider fiscal impact and any necessary statutory changes. The findings from the study shall be submitted to the appropriate committees of the house and senate by January 1, 1989."

Due to the extent and complexity of the problem, it was decided that the joint study group should include other state agencies that also serve abused children. The Texas Youth Commission (TYC), the Texas Education Agency (TEA), and the Texas Juvenile Probation Commission (TJPC), as well as representatives from the private sector, joined TDMHMR and TDHS in the study.

EXTENT OF THE PROBLEM

The maltreatment of children by their parents or caretakers is one of the most pressing problems of the 1980s. The severity of the effects of child abuse and neglect on our nation's youth is growing. Child abuse is dangerous to children and costly to society.

Incidence. During 1987, a total of 108,090 Texas children were alleged victims of child abuse and neglect; confirmed victims numbered 57,067. Using an analogy to put the situation into more concrete terms, one could say that for every two classrooms of children in Texas schools, one or more children are reported abused or neglected every year in Texas. (This analogy is based upon an assumption of 22 children per classroom.) This reported incidence of child abuse and neglect is 22 per thousand, in line with national estimates ranging from 12 to 35 per thousand.

Child abuse and neglect are estimated to be even more extensive than their reported incidence. In its FY '90-91 Legislative Appropriations Request, TDHS estimated that over 427,000 children were at risk of abuse or neglect in Texas during FY '88. According to the National Center on Child Abuse and Neglect (NCCAN), the numbers of abused and neglected children reported to CPS agencies in all states represent only the "tip of the iceberg" (Study of National Incidence and Prevalence of Child Abuse, 1988). NCCAN's 1988 estimates indicate that 86.9 percent of child abuse and neglect cases are never reported.

Lack of Treatment Resources. Funding and staffing limitations mean that many children are not receiving adequate services, even if reported. By the end of FY '89 TDHS will provide in-home services to 60 percent of families in which abuse and neglect is confirmed. However, only one in five of the children whose cases of abuse or neglect were considered "founded" receives needed individual or group therapy (see figure 1-1). Other state agencies have no consistent or effective mandate or means to identify or treat victims of child abuse and neglect.

Social Costs. As illustrated in figure 1-2, which summarizes information from several sources, abused children suffer numerous harmful effects.

Figure 1-1 Identification and Treatment of Child Abuse

Experts think that only 13 out of 100 cases of child abuse are now being identified. Of the 13 percent identified, only one abused child in five receives treatment or about 2.5 percent of the estimated total.

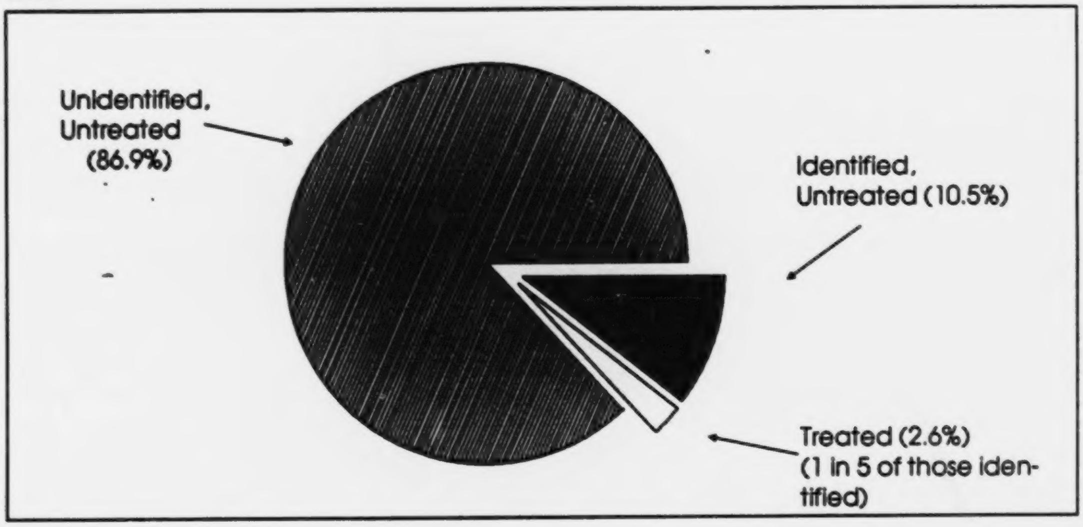
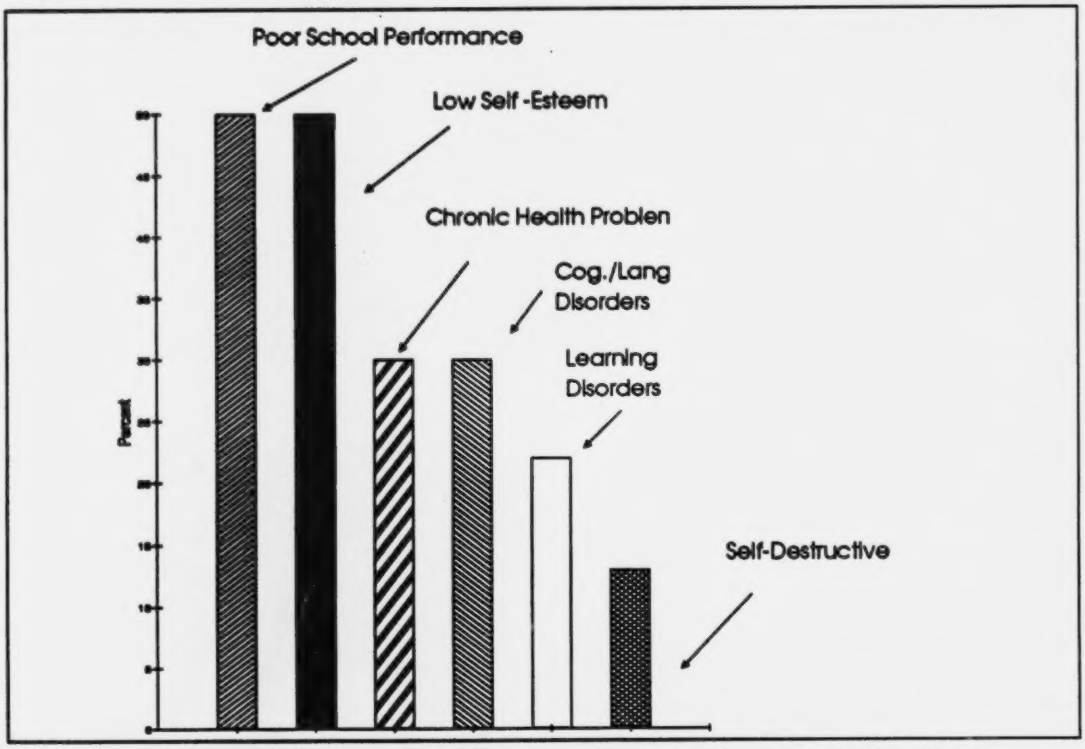


Figure 1-2. Effects of Child Abuse
(Physical, Emotional, and Social)



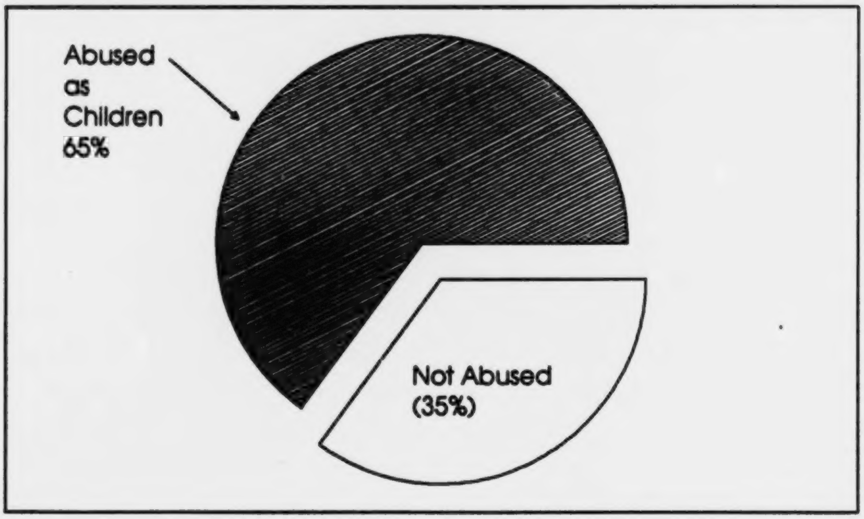
Note: Percentages add to more than 100 percent because the same child suffering several ill-effects of abuse may be counted in more than one category.

- Fifty percent of abused children perform poorly in school, and the same percentage suffer low self-esteem.
- Almost one-third of abused children suffer from chronic health problems and cognitive/language disorders.
- About 20 percent of abused children are characterized as having learning disorders, and over 10 percent are described as self-destructive.

Direct Costs. Society incurs direct costs from child abuse. Some abused children require special education services for learning and emotional problems. Some require social services such as foster care. Some have medical costs. Most victims of abuse and neglect require community-based services; some need institutional care through mental health, educational, child protective, or juvenile justice systems.

Indirect Costs. Substantial indirect costs also result from lack of treatment. Many untreated victims never heal or become fully productive members of society. Adults who were mistreated as children are likely to be substance abusers, to engage in criminal behavior, or to have recurring mental and physical health problems. For example, 65 percent of the inmates in the Ferguson Unit of the Texas Department of Corrections (figure 1-3) had been abused as children (Page, 1979).

Figure 1-3. Percentage of Inmates Abused as Children (Texas Department of Corrections Ferguson Unit)



The Cycle of Abuse. Child abuse has a multi-generational impact that imposes further costs. Victims in one generation may become abusing parents in the next. Evidence shows that some abuse victims begin perpetrating physical and sexual abuse at young ages. Younger siblings, relatives, neighbors, or playmates are their victims.

In 1987, TDHS received 1,687 reports on perpetrators of abuse and neglect under the age of 18. They represent 3.7 percent of all the perpetrators reported in 1987. The majority of these "child" perpetrators were victims of or witnesses to child abuse and neglect during their own childhoods. And these numbers are considered only a fraction of the actual number of juvenile perpetrators. Such facts and projections support the premise that child abuse and neglect is cyclical and spans generations.

TOWARD SOLUTIONS

To stop the cyclical perpetuation of abuse and neglect and to prevent the social costs from escalating any further, treatment services must be provided to victims, to perpetrators, and to families at risk for abusing their children. Addressing the problem of child abuse and neglect directly and squarely can literally save the lives of our Texas children.

What can be done to assist Texas children in obtaining needed treatment services so that they become self-sufficient, productive citizens? The following sections of this report address the problem. Section 2 details the ill effects of abuse. Section 3 assesses service and treatment needs. Section 4 describes services now offered. And Section 5 presents recommendations toward implementing a model treatment program in Texas.

2

Social, Physical, and Emotional Effects of Child Abuse and Neglect

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Violence against children has been occurring for centuries, but the effects have been studied only in recent years. The first legislation protecting children against abuse came in 1894 in New York City. In 1963, political attention focused upon the issue of child abuse and neglect. Eighteen bills to protect child abuse victims were introduced into Congress. Eleven passed. By 1965, mandatory child abuse reporting laws existed in all states. The Child Abuse Prevention and Treatment Act, which funded the National Center on Child Abuse and Neglect, passed Congress in 1974. (For a historical review of legislative action on child abuse in Texas, refer to Section 4.)

Child abuse encompasses physical, emotional, and sexual abuse. Abuse entails acts of commission and failure to protect, whereas neglect entails acts of omission or the failure to adequately care for the physical needs of children. All forms of child abuse and neglect are accompanied by both individual and social effects. The individual effects include physical, emotional, and behavioral aspects (see Appendix A). Social effects include the economic costs to society that result from the requisite intervention of social service, mental health, and correctional agencies and, frequently, special education services.

PHYSICAL EFFECTS

Physical effects of abuse include skin injury: 60 to 70 percent of abused children suffer bruises and welts; 20 to 30 percent incur abrasions, contusions, and puncture wounds; and 5 to 10 percent suffer burns and scaldings (Haughton, 1977). Skeletal injury occurs in 15 to 20 percent of recorded abuse cases (Haughton, 1977). Internal injuries involving brain damage or neuromotor dysfunction occur in 25 to 30 percent of abused children (Martin & Rodeheffer, 1976). The most severe effect of abuse upon children is death. Recorded death rates for physically abused children range from 1 to 25 percent. The average age at death is under three years old (Mitchell, 1977).

The physical effects are visible and shocking. When children are physically harmed, they may come to the attention of authorities, and action may be taken. Emotionally abused children are not as likely to come to the attention of authorities. Emotional effects are not as readily detectable. Much progress has been made in the last 10 years, and the research findings consistently point to numerous harmful emotional consequences of child abuse. These harmful effects ultimately result in enormous social costs.

EMOTIONAL AND PSYCHOLOGICAL EFFECTS

Learning and Developmental Disorders

Cognitive deficits—mental retardation, developmental delays, learning disorders, and poor school performance—occur more often in abused and neglected children (Coons, 1986). Poor academic performance and behavioral problems in school among sexually abused children have been repeatedly demonstrated (Fischer, 1983; Jones, Gruber, & Timbers, 1981;

Nakashima & Zakus, 1977; Rosenfeld, Nadelson, Krieger, & Blackman, 1977).

Over 50 percent of abused children have school-related problems. Twenty-two percent have learning disorders that require special education services (National Clinical Evaluation Study, cited in Daro, 1988). Twenty-five percent of all handicapped students receiving special education services nationwide are victims of abuse or neglect *(Preventing Maltreatment of Children with Handicaps,* 1986). Abused and neglected children often have impaired cognitive development. They have higher rates of mental retardation (Sangrund, Gaines & Green, 1974). Even among infants and preschoolers, those who have been physically abused have lower developmental functioning than infants who are not abused (Applebaum, 1980).

Drug and Alcohol Abuse

Between 60 and 80 percent of adult drug or alcohol abusers have a history of child abuse (Cohen & Densen-Gerber, 1982). Similar findings have been reported among victims of sexual abuse, with studies indicating that many develop drug and alcohol abuse problems (Hoagwood, 1987; Jones, Gruber, & Timber, 1981).

Suicide

Abused children have a much higher incidence of suicide and other self-destructive behaviors than children who have not been mistreated (Green, 1978). Sexually abused children make more suicide attempts than nonabused children (Hoagwood, 1987; Hunter, Kilstrom, & Loda, 1985; Silver, Boon, & Stones, 1983).

Personality and Mood Disorders

Depression is highly characteristic of children who have been physically or sexually abused (Hoagwood, 1987; Fischer, 1983; Nakashima & Zakus, 1977; Elmer, 1977). The theme of depression and loss is common among adult therapy clients who were abused as children (Silbert & Pines, 1980; Tsai & Wagner, 1978).

Character disorders, psychosis, chronic traumatic neurosis, and dissociative disorders (i.e., multiple personality disorders) have been reported among children who have been abused or neglected (Bliss, 1984; Brickman, 1984; Gelinas, 1983; Blumberg, 1979; Lewis, Shanok, Pincus, & Glaser, 1979). Bliss, for example, found that 40 percent of the patients in his study had been physically abused as children, and 60 percent had been sexually abused.

Poor Peer Relationships

Abused children have deficits in social skills and thus have difficulty forming and maintaining friendships. These deficits place them at risk for suicide and criminal behaviors. Physically abused children are less socially interactive (Jacobson & Straker, 1982). Sexually abused children have difficulty trusting others. Their interpersonal relationships with their peers are often disruptive and dysfunctional (Finkelhor, 1984; Herman, 1981).

Self-Blame

Children who are sexually abused often blame themselves for having been abused. They carry this blame into adulthood (Hoagwood, 1987). Self-blame as a child is consistently associated with poor adjustment in adulthood, including low self-esteem, depression, suicide attempts, and eating disorders (Hoagwood, 1987). Some victims may express their anger through self-blame or self-contempt (Courtois & Sprei, 1988). Abuse and neglect victims who continue to blame themselves are more likely to become victimized again (Anderson-Barboza, 1983).

Lowered Self-Esteem

Low self-esteem is found uniformly among child victims of all types of abuse and neglect. Children incorporate messages from adults into the development of their self-image. When children are maltreated (either through physical, sexual, or verbal abuse) they view themselves as "bad" and feel that they deserve to be mistreated. This feeling perpetuates a vicious cycle: their self-image leads them to behave in ways that solicit adult disapproval which, in turn, reinforces their own negative self-image. Abused children tend to be insecure and to have feelings of inadequacy and low self-worth (Oates, Forrest, & Peacock, 1985; Kinard, 1980).

Sexually abused children consistently exhibit low self-esteem and the inability to form and maintain meaningful interpersonal relationships (Bessett, 1985; Finkelhor, 1984, 1979; Herman, 1981).

In Finkelhor's 1979 sample of 796 students at six colleges, 28 percent of whom had been sexually abused in childhood, both male and female abuse victims displayed lower self-esteem than their peers who had not been victimized. Silbert & Pines (1983) found that 98 percent of their subjects reported negative feelings about themselves and about their sexuality. Furthermore, the attempt of sexually abused victims to make sense of their victimization may persist for 20 or more years, and this "search for meaning" is inversely related to adjustment (Silver, Boon, & Stones, 1983).

Finkelhor (1979) found that all sexually abusive acts, from fondling to penetration, lower the child's self-esteem. Activities involving exhibition or fondling, for example, were reported to be as traumatic as intercourse. Although father-daughter incest is the most devastating, sexual activity with any family member is just as damaging as sexual activity with a stranger (Finkelhor, 1984).

SOCIAL AND FISCAL EFFECTS

The social and fiscal effects of child abuse and neglect are significant. Child abuse and neglect place a tremendous and continual burden on social service resources. Child abuse also violates our humanitarian values and concerns and results in incalculable losses in human potential.

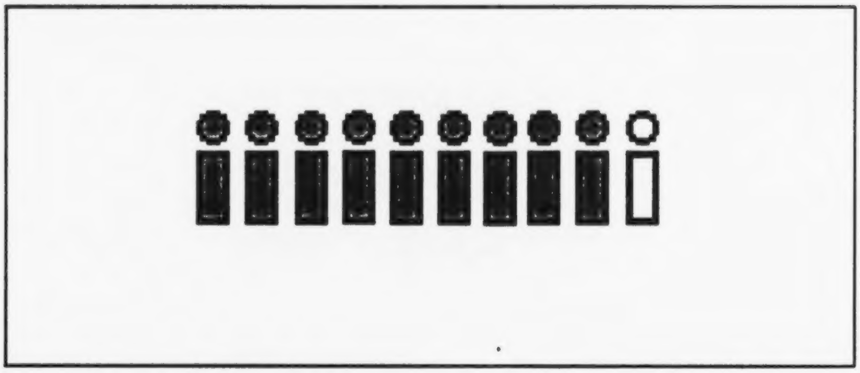
Criminal Behaviors

Victims of child abuse are often involved in criminal activities throughout their lifetimes. They may become child abusers themselves. They may become murderers. Society pays through the cost of institutionalizing or otherwise monitoring the behavior of perpetrators. This subsection summarizes major findings about criminal behaviors of child abuse and neglect victims.

Juvenile Delinquency. One response of abused or neglected children is to become aggressive, and juvenile delinquency rates are high among such children (McCord, 1983; Alfaro, 1981; Steele, 1976). As many as half of physically abused and neglected victims commit serious crimes (McCord, 1983). Juvenile delinquency also commonly occurs among victims of sexual abuse (Brassard, Tyler, & Kehle, 1983; Fischer, 1983).

Murder. Criminals imprisoned for murder were frequently victims of abuse in childhood (King, 1975; Easson & Steinhilber, 1961; Duncan, Frazier, Litin, Johnson, & Barron, 1958). Up to 90 percent of murderers (figure 2-1) were physically abused as children (Easson & Steinhilber, 1961; Duncan et al., 1958).

Figure 2-1. Percentage of Murderers Abused as Children
Without claiming any one-to-one relationship of cause and effect, various studies yield the striking finding that as many as 9 out of 10 murderers were abused as children.



Runaway Youth. At least 50 percent of runaway youth have been abused physically. An even greater percentage of runaways have been sexually abused (Silbert & Pines, 1981; Louie, Campiglia, James, & DeWitt, 1979). Some children who run away also become involved in prostitution. One study of prostitutes demonstrated that 60 percent had been sexually abused as children, and 70 percent of those victims reported that their abuse had affected their decision to become prostitutes (Silbert & Pines, 1983).

Child Abuse. Abuse tends to perpetuate itself. Many victims of physical abuse become physically abusing parents (Steele & Pollock, 1974; Spinetta & Rigler, 1972). In addition, some research has indicated that male victims of sexual abuse tend to become perpetrators of sexual abuse themselves (Bessett, 1985).

Costs of Child Abuse and Neglect

Some children respond to abuse and neglect by becoming aggressive and engaging in criminal activities, as discussed in the preceding subsection. These children often end up being supported by the state through the criminal justice system.

Other children withdraw emotionally and become hard to reach. They are psychologically damaged. They may be institutionalized or may enter any number of social service systems. They may be placed in substitute care situations such as foster homes. If not treated, many turn to substance abuse and other unhealthy and destructive coping mechanisms. Still other children are seriously injured and have permanent developmental or physical deficiencies. These victims require continued medical attention and special education services.

In summary, there is overwhelming evidence that victims of child abuse and neglect often fail to become productive members of society. Eventually many victims of child abuse end up in one social service system or another. As adults, abused and neglected children are more likely to be in public assistance programs, to have employment difficulties, to have mental health problems, and to overuse health care systems.

Some Costs of Untreated Child Abuse. Maltreated children experience many harmful physical and emotional consequences of abuse. The effects are often severe and long-term, requiring intervention through social service agencies, special education services, community mental health centers, or juvenile and criminal justice systems. To take one example, Texas spends over $23,000 each year to maintain one child in TYC. In Fiscal Year (FY) 1988, TYC served an average daily population of over 3,800 children. Half of these children were served in residential programs at a cost of $64 per day or over $44 million in FY '88.

The Texas Department of Human Services (TDHS) confirmed 44,694 abuse and neglect victims in FY '88. To further illustrate the enormous costs of child abuse, consider only the 13,230 confirmed by TDHS as being physically abused. If only half this number require hospitalization for five days each, the medical costs would exceed $10 million. If 25 percent require special education services, the educational costs to the state for one year would be $17 million. If only 1 percent suffered permanent developmental disabilities, the cost of community services would be an additional $0.5 million each year. Increased rates of substance abuse, emotional problems, and family disruption also impose substantial direct costs on service agencies.
(The cost estimates in the preceding paragraph are based on Daro 1988 and may vary somewhat in Texas. It should be noted that these are not actual costs incurred by state agencies. Rather they are estimates for treating the consequences of physical abuse and only partially illustrate the continuing costs of serving children who are abused and neglected.)

Prevention and Treatment—Costs with Potentially Great Benefits. Preventing and treating child abuse can also be costly. "The long-range costs of failure to prevent, intervene and treat child deprivation are beyond calculation and have not yet received appropriate attention" (National Council of Juvenile and Family Court Judges, 1986). Appendix B presents a summary of problems and costs associated with the maltreatment of children from Daro's recent analysis (Daro, 1988).

Findings suggest that the costs associated with primary and direct treatment efforts such as home-based services, respite care, and therapy are well worth their initial expense. Not to provide these services ultimately costs society much more (c.f., National Council of Juvenile and Family Court Judges, 1986 and Daro, 1988).

Effective treatment of child abuse can be provided through home-based services. Other treatment programs, such as school-based therapy, a method that provides a cost-effective system for reaching abused children, can be provided at a cost of $300 to $900 per child per year.

Residential treatment programs in Texas, such as the Waco Center for Youth and the Corsicana State Home, have fairly high success rates of 45 to 60 percent. The cost of providing psychiatric treatment services at Waco Center for Youth is approximately $23,000 per client per year (at an average stay of six months). TDMHMR has requested $2.3 million for FY '89 to serve abused children in TDHS conservatorship. At a cost of approximately $23,000 per client for an average stay of six months, 100 abuse victims will be treated, 60 of whom may not need state services again.

There are workable solutions to the problem of child abuse and neglect. Section 5 presents recommendations to address the problem in Texas. These include multiagency programs to provide more cost-effective services to abused children and to expand the treatment of both victims and perpetrators. These solutions are designed to stop the cycle of abuse and to actively address the problem of child abuse before the occurrence of its predictable and numerous harmful effects upon children and upon society.

3

Service and Treatment Needs of Maltreated Children

SECTION 3 CONTENTS

CLINIC-BASED THERAPY (3-1)
RESIDENTIAL-BASED THERAPY (3-2)
THERAPEUTIC DAY TREATMENT (3-3)
SUPPORT GROUPS (3-3)
FAMILY-BASED SERVICES (3-4)
MODEL SYSTEM-CONTINUUM OF SERVICES (3-4)
BUILDING A COST-EFFECTIVE SYSTEM (3-7)

The Joint Study Committee reviewed current methods for treating abused children. Treatment is defined as therapeutic intervention directed toward improving the psychosocial adjustment of individuals and families. Treatment includes the (re)habilitation of families to eliminate family isolation, abusive patterns, and individual dysfunctional behavior styles. The following treatment methods were identified: clinic-based therapy, residential-based therapy, therapeutic day treatment, support group therapy, and intensive family-based services. Each method has two components: (1) a therapeutic approach and (2) a system through which the service is delivered.

CLINIC-BASED THERAPY

Outpatient therapy is a traditional treatment method. The child and family receive therapy through private or public mental health specialists. This approach focuses on underlying causes of abuse and responses to abuse as symptoms of unhealthy family interaction processes. Individual, group, and family counseling are provided.

Therapeutic treatment is necessary for victims of abuse. The abusive home results in retarded development and emotional problems and teaches the child deviant patterns of behavior and interaction. These patterns are often perpetuated in subsequent relationships unless identified and modified (Conner, 1987; Hoier, 1987). If the home poses a continual threat to the child, the child may be removed temporarily or permanently. The abused child who is placed in a foster or adoptive home is still in need of therapy. TDHS contracts with local community mental health centers and private practitioners for these services.

RESIDENTIAL-BASED THERAPY

Residential programs provide the stability of daily routines and positive adult relationships that many abused and neglected children have not experienced. Most residential treatment facilities are designed for specific populations such as the emotionally disturbed, the developmentally disabled, or the substance abusing. To be admitted into such a facility, the abused children must have a primary diagnosis qualifying them for that program. Even if the abused child is admitted, the facility may not have a program that specifically addresses the issue of abuse. Appendix C describes a residential treatment program specifically designed to address the needs of abused children.

TDHS contracts with private providers for residential care services and also uses TDMHMR psychiatric in-patient services. Psychiatric in-patient services are provided by TDMHMR through state hospitals at Terrell, Wichita Falls, Austin, San Antonio, and Big Spring. The Day Break Children's Program of the Southeast Texas TDMHMR Center also provides such care.

TDMHMR has only two statewide programs that provide long-term intensive residential treatment—the Vernon Drug Dependent Youth Program and the Waco Center for Youth. The latter represents a successful joint program between TDMHMR and TDHS. Half of the facility's 100 beds are used by children in conservatorship of TDHS. TDMHMR facilities operate under provisions of the Texas Mental Health Code.

THERAPEUTIC DAY TREATMENT

Day treatment programs provide individual, group, and family therapy to parents and children. Through therapeutic games and other play activities, children are allowed to express feelings of fear, anger, and sadness related to their experiences of abuse.

Programs are designed to enhance physical, language, and social-emotional development of abused children because many show delays in these areas. Parents are trained to work effectively with their children. Parents also receive encouragement and support from other families with similar problems.

Day treatment services are currently being provided in some parts of Texas through community mental health centers. The Austin-Travis County Day Glow Program serves children ages 3 to 12. The Dallas County TDMHMR Center has an infant and abusive parent program for children ages 0-3, the Tepyac Preschool Day Program for children ages 3-5, and an after-school treatment program for children ages 6-12. The Harris County TDMHMR Authority also has a day treatment program for adolescents ages 13-17.

SUPPORT GROUP THERAPY

Parent groups that target abusing families are a standard self-help technique in the treatment of child abuse. Some support groups are led by trained therapists. For example, a private practitioner in San Jose, California, Hank Giaretto, is founder and director of the Child Sexual Abuse Treatment Model. This highly effective model is used nationwide. A self-help group, Parent's Unlimited, also grew out of this program. Some groups for adults who were victimized as children, such as Parents Anonymous and Incest Survivors Anonymous, are purely self-help groups.

INTENSIVE FAMILY-BASED SERVICES

Intensive family-based services provide an alternative to the extensive use of substitute care for abused and neglected children. This intervention ensures protection for children at risk of further abuse through the immediate introduction of a therapist into the home environment. The therapist provides nurturing and support to the family and teaches appropriate parenting behavior. The parent-training component is crucial to eliminating child maltreatment in future generations. The child tends to perpetuate the abusive relationship with the parents in subsequent relationships unless behavior patterns are changed.

Intensive family-based services have been effective for families of status offenders, adjudicated delinquents, and emotionally disturbed children and their families. The program provides an appropriate service at a much lower cost than foster care or institutional placement.

Intensive family-based services are currently provided through the Texas Department of Human Services in Houston, San Antonio, El Paso, and Dallas/Fort Worth.

TDHS and TDMHMR recently applied to the Federal Office of Human Development Services for joint funding to provide intensive family services to behaviorally disordered children and families in Houston and South Texas.

MODEL TREATMENT SYSTEM: A CONTINUUM OF SERVICES

Desirable Features of a Model System. The committee concluded that a model system for treatment of child abuse in Texas should—

- incorporate a *continuum of services* that includes prevention as well as treatment;
- draw upon existing state and local resources in order to (a) reduce duplication and costs and (b) produce the most comprehensive and effective treatment of abused children;

- provide for analysis of administrative and resource issues; and
- employ a combination of all treatment methods studied.

The comprehensive services needed are diagrammed in Appendix D. Appendix E depicts which services are available in Austin-Travis County.

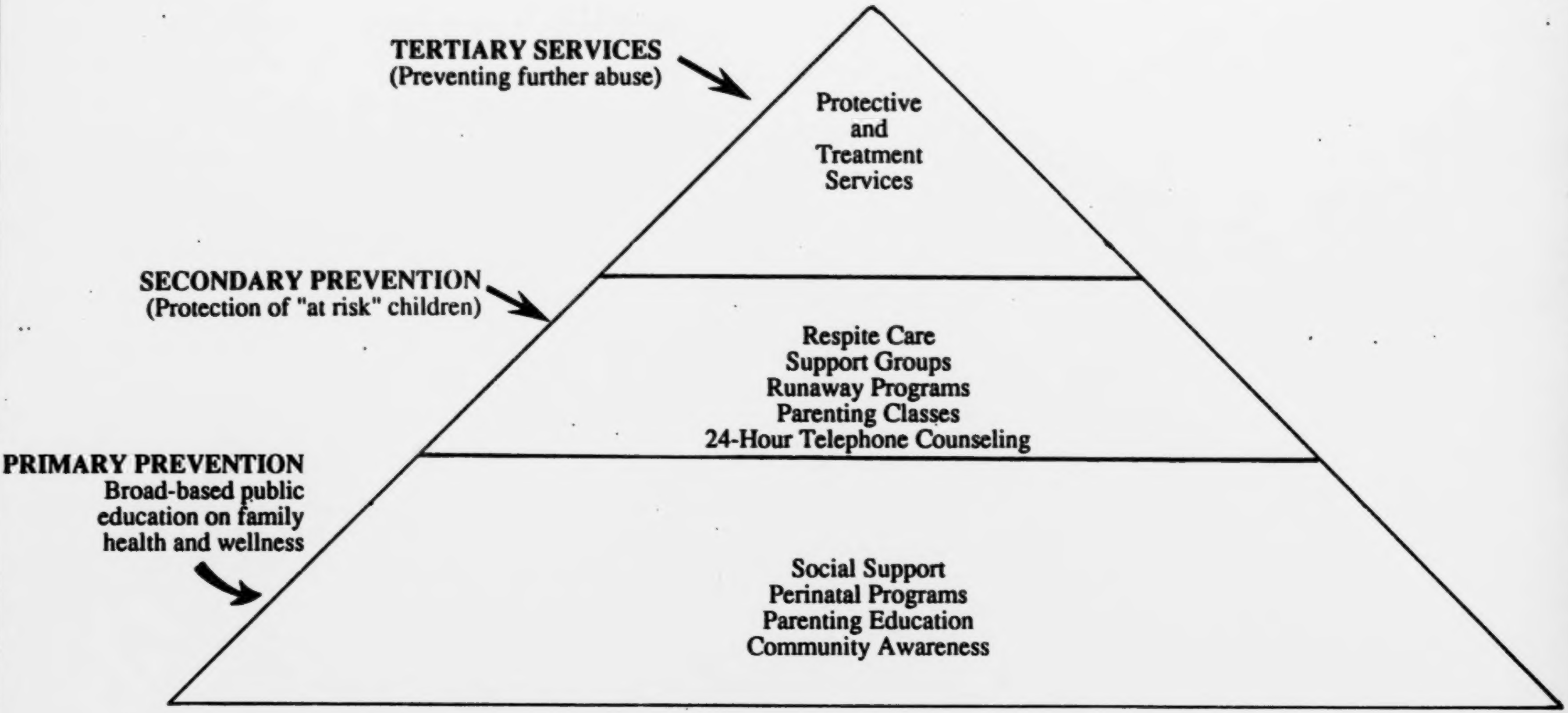
The Oregon System. The State of Oregon has developed and implemented a system similar to the one envisioned for Texas. Protective services and treatment activities are coordinated between the Human Services and Mental Health departments. Included in this service continuum are a Family Sexual Abuse Treatment Program; a High-Risk Infant Treatment Program: a Victim Treatment Group; Non-Offending Spouse Treatment; and Intensive Family Services (see Appendix F). The Oregon system also includes an extensive treatment program for juvenile sexual offenders (see Appendix G). The treatment continuum provides community-based services as well as residential care.

Levels of Intervention. To understand the system envisioned for Texas, it is important to view the service delivery system in terms of three levels of intervention: primary, secondary, and tertiary (see figure 3-1 and Appendixes D and E for details).

Primary prevention refers to programs, services, and structures of the society aimed at supporting positive family functioning. Primary prevention seeks to prevent child maltreatment from ever occurring. These services are offered voluntarily to all members of the community and seek to promote wellness. Primary prevention aims to support healthy family interactions and to positively affect the attitudes, values, and awareness of all people in the community.

Secondary prevention refers to support services for persons who are "at risk" of child maltreatment. Secondary services are more problem-oriented and seek to prevent future parent-child problems by focusing on the stresses experienced by high-risk families (such as low-income families, single-parent families, or "blended" families). Child maltreatment may not have occurred, or may never occur, in these families, but the probability is much greater.

Figure 3-1. Levels of Intervention in a Model Program for Treatment of Child Abuse


TERTIARY SERVICES
(Preventing further abuse)
Protective
and
Treatment
Services
SECONDARY PREVENTION
(Protection of "at risk" children)
Respite Care
Support Groups
Runaway Programs
Parenting Classes
24-Hour Telephone Counseling
PRIMARY PREVENTION
Broad-based public
education on family
health and wellness
Social Support
Perinatal Programs
Parenting Education
Community Awareness

Primary prevention reaches a very broad target group, secondary prevention aims at a smaller though still very large population, and tertiary services focus on children who have been abused. (See Appendix D for more details.)

Tertiary services are offered after child abuse or neglect has occurred. In this sense it is reactive, offering protection and treatment after the fact. Tertiary services are also preventive. They seek to prevent further abuse to children and to prevent them from becoming perpetrators of abuse in the future.

BUILDING A COST-EFFECTIVE SYSTEM

The most cost-effective way to implement a continuum of services system is to use existing service delivery mechanisms. This finding is supported by a draft report being prepared for the 71st Legislature by the Health and Human Services Coordinating Council on reorganization of services to children and youth. The following section describes the existing state systems in Texas for treating child abuse victims and identifies gaps in services.

4

State Agency Resources for Combating Child Abuse and Neglect

SECTION 4 CONTENTS

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The entire community suffers from the criminal, self-abusive, and destructive behaviors that result when child abuse victims do not receive adequate protection and treatment. As a result, the prevention and treatment of child abuse is everyone's concern and everyone's responsibility. By drawing upon and developing cooperative networks among public and private organizations, the treatment and prevention of child abuse can be approached most efficiently and effectively. In the preceding section, the committee recommended a model that includes such networking approaches. The present section, however, describes only those resources for treating child abuse and neglect that are available from the five state agencies involved with the problem.

STATE AGENCIES INVOLVED IN TREATING CHILD ABUSE

Five state agencies involved with Texas children are in a position to address child abuse and neglect: the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, the Texas Education Agency, the Texas Youth Commission, and the Texas Juvenile Probation Commission. Each agency has a certain mission and related legal mandates with regard to the Texas youth population. Each agency offers services to abused children. The responsibilities of each agency for recognition and treatment of child abuse and neglect are presented in this section, following a history of their involvement in the issue.

HISTORY OF TEXAS LEGISLATION ON CHILD ABUSE

Until the late 1850s, youth over the age of seven were treated as adults in Texas. Treatment of children has improved only gradually in the 130 years since 1850. Between 1856 and 1905, laws concerning treatment of youth were confined to improvement in conditions for juveniles who exhibited criminal behavior or were institutionalized.

It was not until the early 1900s, with the enactment of the Texas Juvenile Act (1907), that issues such as dependency and neglect were recognized. In 1919 the Waco State Home for dependent and neglected children was established. In 1931 the legislature assigned responsibility for neglected children to a state agency, the Division of Child Welfare, which was part of the Board of Control.

With the transfer of the Division of Child Welfare to the newly created Texas Department of Public Welfare in 1939, public interest and participation in services for abused and neglected children began to increase. Over the next three decades, three new state agencies were created to address the needs of youth—the Texas Education Agency in 1949, the Texas Youth Council in 1957, and the Texas Department of Mental Health and Mental Retardation in 1965 (originally established in 1949 as the Board of State Hospitals and Special Schools). In 1969, Title IV-B of the Social Security Act required statewide protective services for children.

Further legislation, funding, and public awareness efforts during the 1970s extended the protective services available to children. Highlights in the 1980s included (1) creation of the Texas Juvenile Probation Commission and juvenile probation departments in all Texas counties and (2) establishment of the Children's Trust Fund. A bill requiring in-service training on recognition and reporting of child abuse for educators in all Texas school districts was enacted in the 69th Legislature and repealed by the 70th Legislature. Statutory definitions of child abuse and neglect were enacted by the 70th Texas Legislature.

A full chronology of events pertaining to the development of agency involvement in the treatment of abused and neglected children is provided in Appendix H.

TEXAS DEPARTMENT OF HUMAN SERVICES

Mission

A division of the Texas Department of Human Services (TDHS), the Protective Services for Families and Children (PSFC) Branch, is mandated by Title 2 of the Texas Family Code to protect children from harm by their parents or others responsible for their care. Through its Child Protective Services (CPS) Program, TDHS encourages parents and other family members to solve problems that may lead to abuse or neglect. The program's main objective is to prevent further harm to children while preserving the family unit. If preservation is not possible, TDHS may petition a court to remove children from their home and temporarily place them with substitute families or caretakers. If the family cannot resolve its problems so that the children can return home, TDHS may recommend to the court that the parent/child relationship be terminated and the children placed with other permanent families or caretakers.

Intake and Investigation. After a report of abuse or neglect is made to CPS, the report is assigned a priority, and a caseworker contacts the family to determine whether there is further risk to the child and to initiate action to protect the child if necessary. Before reaching a conclusion about the validity of the report, the caseworker may contact friends, relatives, neighbors, medical and school personnel, and others who may have knowledge of the child and family.

In-Home Services. When the need for continuing protective services has been identified but there is no need to remove a child from the home, a service plan is developed with the family to prevent further abuse or neglect. Through in-home services, workers try to strengthen the family's ability to meet the child's needs. Workers focus on problems that contributed directly to the abuse or neglect. Where available, various community resources are used to plan services for the family.

Foster Care. When a child's safety is believed to be seriously endangered by remaining in the home, the caseworker and supervisor seek court approval to place the child temporarily in foster care. In the past, foster care was often the only means of protecting children from further harm, and children sometimes remained in such care a long time without permanent parental figures. In recent years, CPS has emphasized "permanency planning" for children in foster care. That is, children are returned home as quickly as possible or, if that is not feasible, alternative permanent plans are made for children so they can grow up in a family with whom they can have a sense of identity.

Adoption. Although most children are returned to their parents or relatives from foster care, others cannot be returned for a variety of reasons. TDHS seeks termination of parental rights for many of those children to place them in adoptive homes. The purpose of the Department's adoption services is to provide suitable homes for children in its conservatorship who need adoption, rather than to meet the needs of persons interested in adoption.

To expand adoption opportunities for these children, TDHS has implemented an adoption subsidy program for the "special needs" child. Subsidy costs are less than maintaining a child in foster care and may be used to assist adoptive parents with placement and maintenance activities. The Department also purchases adoption services from private agencies and operates the Texas Adoption Resource Exchange to increase the pool of prospective adoptive families.

Abuse Hotline. The toll-free telephone hotline was established in 1974 to ensure 24-hour statewide intake coverage for the CPS Program. Also, TDHS did not want to exclude anyone from reporting because of long-distance charges. In addition to relaying reports to local offices for investigation, hotline employees provide (1) policy information about child and elderly protective services and (2) information and referral for children and the elderly who need services.

Additional Services. Additional services offered through the CPS Program include the Interstate Compact on the Placement of Children, the Family Violence Program, and services to truants and runaways.

Legal Mandate

TDHS is designated as the single state agency in Texas to administer Titles IV, XIX, and XX of the Social Security Act. This act specifies the obligations of CPS toward Texas children. Further legal mandates are specified by state laws that require TDHS to protect children from abuse, neglect, or other harm. The 1974 Texas Family Code extends the responsibilities of TDHS to Texas children and mandates the Department to protect children from harm by their parents or others responsible for their care.

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Mission

The purpose of the Texas Department of Mental Health and Mental Retardation (TDMHMR) is to provide effective administration and coordination of mental health and mental retardation services at the state and local level. The goal of the agency is to provide a comprehensive range of services including support care, treatment, and habilitation.

Program Services

Senate Bill 633 (69th Legislature, Regular Session, 1985) requires TDMHMR to identify core or basic services to be provided through state facilities and community mental health and mental retardation facilities. It is important to note that at present these services are not available to children and adolescents at the same level that they are provided for adults.

Mental Health Residential Services. Twenty-four hour residential services, either through TDMHMR facilities or contracted facilities, are provided to clients in each service area in the state.

Mental Health Client and Family Support Services. A number of program areas are directed to the provision of client and family support. These include the Crisis Hotline and the Crisis Intervention Team, both of which are operated 24-hours a day to provide support or other necessary services to clients in immediate crisis. Clients who are demonstrating life-threatening behavior or acutely dysfunctional behavior are also provided with multidisciplinary assessments, support services for their family members, counseling, and medication-related services.

Mental Health Psychosocial Rehabilitation Services. This program area includes services that help clients continue to function in the workplace and community. The program consists of activities designed to ensure the development of social networks and provides vocational services, including prevocational training, vocational training, and sheltered employment.

Mental Retardation Residential Services. Out-of-home respite care is offered during crises or specific events to provide relief to families or staff who are the usual care providers.

Mental Retardation Client and Family Support Services. Diagnostic and evaluation services are completed before a client receives mental retardation services. Family support services include in-home health services, homemaker services, physical adaptations to the home, fiscal assistance, in-home respite care, or any necessary support service that allows the family to better provide a family residence for a member who is mentally retarded.

Case Management. All clients can be screened for case management services. Program services are directed according to a case management system, which designates a case manager to assist the client in identifying and coordinating appropriate community resources while maximizing the client's own participation in securing these services and managing his/her own life.

Child Abuse Services. Mental health services for children are not extensive due largely to lack of specific funding and staffing resources. There are day treatment programs in Travis, Dallas, and Harris counties for children and adolescents and some outpatient services provided through the mental health authorities. However, due to the lack of early intervention, abuse and neglect victims often do not come to the attention of TDMHMR until they have already become so intensely emotionally disturbed as a result of the abuse that they require residential treatment. In response to the needs of severely disturbed abused children, a psychiatric treatment center, the Waco Center for Youth, was established 1979.

Legal Mandate

TDMHMR was created by the Mental Health and Mental Retardation Act of 1965 to provide for effective administration and coordination of mental health and mental retardation services at the state and local level.

With the enactment of Senate Bill 298 (70th Legislature, Regular Session, 1987), TDMHMR became statutorily responsible for the investigation of child abuse, neglect, and exploitation occurring in facilities operated, licensed, certified, or registered by the Department. TDMHMR is also, like all state agencies, required by law to report all allegations of abuse, neglect, or exploitation beyond this mandate to TDHS.

TEXAS EDUCATION AGENCY

Mission

The purpose of the Texas Education Agency (TEA) is to provide a public education to all school-age children in Texas. TEA's involvement in the problem of child abuse and neglect began as part of its compliance with House Bill 986 (69th Legislature, Regular Session, 1985), which required all Texas school districts to provide in-service training on the recognition and reporting of child abuse and neglect to Texas educators. This bill was repealed during the 70th Legislature.

Program Services

TEA offers no treatment programs specifically for abused and neglected children. The Agency's involvement extends only to the requirement that educators report signs of abuse or neglect in students.

TEA provides assistance to Texas school districts and encourages them to—

- expand in-service training on child abuse and neglect to include all school personnel;
- develop an in-service program that includes signs and symptoms of the four types of child victimization, legal responsibility to report child abuse or neglect, policies and procedures for reporting abuse or neglect, and plans for implementing personal safety programs;

- designate a child advocate committee to handle abuse or neglect cases;
- consult the *Handbook on the Implementation of Anti-Victimization Programs for School Children*;
- plan parent-teacher programs and enlist the cooperation of the community in preventing abuse or neglect;
- establish clear discipline guidelines and ensure that staff follow the districts' policies;
- inform all staff that districts must cooperate fully with any TDHS investigations, including interviews of children at school;
- provide the in-service training program on child abuse and neglect annually for all new employees;
- repeat the training for all personnel every five years; and
- contact their Regional Education Service Center for assistance in planning the training programs.

TEA has also designated its Office of Comprehensive School Health Programs to handle questions about school districts' involvement in child abuse and neglect cases.

Legal Mandate

TEA is mandated to provide a public education for all school-age children in Texas. From 1985 to 1987, all school districts in Texas were mandated through House Bill 986 to provide in-service training on child abuse and neglect to all certified professional educators (this mandate was repealed in 1987). The purpose of the training was to enable educators to recognize and respond to signs of abuse or neglect in students. School districts are still encouraged to provide appropriate training on a continual basis.

TEXAS JUVENILE PROBATION COMMISSION

Mission

The Texas Juvenile Probation Commission (TJPC) was established by the Texas Legislature in 1981 to provide probation services to juveniles throughout the state. TJPC's purpose is to improve the effectiveness of probation services, to offer juveniles alternatives to commitment (by providing financial aid to juvenile boards for the establishment and improvement of juvenile probation services), to establish uniform probation administration standards, and to improve communication between state and local entities within the juvenile justice system. The Commission was also mandated by the 69th Legislature in 1985 to provide minimum standards for juvenile detention facilities.

Program Services

TJPC provides state aid funding, monitoring for compliance with state standards, training, and technical assistance to all juvenile probation departments in the state. As the following paragraphs describe, the Commission is active in developing program services related to abused or neglected juveniles.

Training. TJPC is responsible for or involved in training program participants on how to identify, intervene in, treat, prevent, and report child abuse. Topics covered in training include prevention and investigation, victim-witness, family violence, personality traits of runaways, nonviolent crisis intervention, and working with perpetrators and victims. Training is provided to judges, juvenile boards, juvenile court staff, prosecutors, police officers, Alcoholic Beverage Commission agents, juvenile justice officials, child care workers in group residential settings, and foster home workers and parents. Certification of juvenile probation officers in Texas also requires specialized training, which includes child abuse issues.

Foster Home Project. Juvenile probation departments were encouraged to develop a network of foster homes through this program until lack of funding forced abandonment of the project. At present, 32 counties have such programs, which are locally funded. Although data collection methods do not allow the documentation of the number of children in these programs who have been victims of abuse or neglect, current research supports the notion that a significant number are in fact victims of abuse or neglect.

Challenge Grants. TJPC operates a challenge grant program in nine counties for the placement of multi-problem children. The children must be under the jurisdiction of a juvenile court for delinquent conduct or conduct in need of supervision and must also be abused, neglected, or mentally retarded.

Border Children Justice Project. This program, operated in conjunction with county governments and the government of Mexico, aims to provide a more cost-effective and humane response to juvenile crime committed by children who are citizens of Mexico.

Parenting Training. The Commission provides technical assistance training to juvenile probation departments on the design, implementation, and management of effective parenting programs. A key focus is on how these programs can be used as effective family intervention tools in the prevention of further delinquency and child abuse. Recognizing the relationship between abuse or neglect and delinquency, the Commission is actively involved in further developing parent training and support groups as well as adolescent support groups, especially in rural counties where no such services are available.

Legal Mandate

The Texas Juvenile Probation Commission was mandated by the 67th Legislature in 1981 to (1) make probation services available for juveniles throughout the state; (2) improve the effectiveness of probation services; (3) offer alternatives to the commitment of juveniles by providing financial aid to juvenile boards for the establishment and improvement of probation services; (4) establish uniform probation administration standards; and (5) improve communications between state and local entities within the juvenile justice system.

TJPC was also mandated by the 69th Legislature in 1985 to provide minimum standards for juvenile detention facilities. The Commission carries out its responsibilities by distributing state aid to county juvenile boards, providing support services to county juvenile departments, offering training and certification of probation officers, providing technical assistance and legal advice, monitoring local department activities, and maintaining and reporting statistical data on juvenile activity in Texas.

TEXAS YOUTH COMMISSION

Mission

The Texas Youth Commission (TYC), originally established as the Texas Youth Development Council in 1949 and the Texas Youth Council in 1957, is responsible for rehabilitating youth who have been committed by the courts for delinquent conduct. Youth are adjudicated delinquent between the ages of 10 and 17. The goal of TYC is to protect society through rehabilitation of the youth offender.

Program Services

TYC provides for youth committed into its care, custody, and control. It provides institutional services, community-based services, special services, and parole services.

Institutional Programs. These programs provide institutional care for children 13 years of age and older and include a facility for violent offenders and training schools for nonviolent offenders. In addition to academic and vocational education programs, the training schools provide a broad array of services including a daily group session and special group treatment for problems such as substance abuse, sex offenses, and arson.

Community-Based Programs. These programs provide for less restrictive local placements in the community through TYC halfway houses and community contract programs. Programs range from a small foster home to private residential treatment centers for the emotionally disturbed to psychiatric hospital placements for youth with more severe needs.

TYC Residential Treatment Center. TYC operates a treatment center that serves severely emotionally disturbed delinquents who are not eligible for placement in private treatment centers, usually due to the committing offense or aggressive and assaultive behavior. The residential center was originally set up in 1982 to serve emotionally disturbed children.

Parole Program. This program provides for follow-up continuum of care for youths released home on parole after they have completed one of the above programs.

Determining Placement. All of these programs care for the needs of youth. Some of the institutions have very specialized programs for violent offenders, sex offenders, arsonists, drug and substance abuse violators, repeat offenders, and emotionally disturbed youth.

Abuse and neglect is not a variable in itself that determines where a child is placed. Placement is determined by a combination of other factors such as prior placements, offenses, mental health needs, "run" risk, and community risk. In April of 1988, abuse and neglect became a separate, identifiable variable on the Commitment Summary. When children are designated as emotionally disturbed at the Statewide Reception Center, they are usually placed in a community residential treatment center or in TYC's treatment center. Whether or not a child entering the TYC system is a victim of abuse or neglect cannot always be identified. In all cases placement is contingent upon meeting the child's needs and placing the child as close to home as possible.

Legal Mandate

The original enabling legislation for TYC was in Article 5143d, Tex. Rev. Civ. Stat. Ann. and is now codified in Chapter 61 of the Human Resources Code.

AGENCIES' COMMON CONCERNS

The Texas Department of Mental Health and Mental Retardation, the Texas Department of Human Services, the Texas Education Agency, the Texas Juvenile Probation Commission, and the Texas Youth Commission are the five state agencies that provide social, mental health, educational, and correctional services to Texas youth. All have concern with and understanding of the problems that childhood abuse and neglect causes the individual youth and the community.

Except for TEA, which serves all children receiving a public education, the agencies recognize that if many of their clients had not been victims of abuse or neglect, they would not have come to the attention of the state agency in the first place. Except for TDHS, the other four agencies have no legal mandate to treat child abuse and neglect victims. The only requirement is that these agencies report any evidence of abuse and neglect to TDHS. All agencies, however, feel that the needs of their clients would be furthered, and the burden of the community lightened, if there were multi-agency programs to prevent and treat the serious problems that result from child abuse and neglect.

Lack of Treatment Resources

A serious disparity exists between the resources available to the state agencies that serve children who are victims of abuse and neglect and the very large number of children in Texas who need treatment services. At a minimum, state agencies collectively should be able to serve the children in their custody. At present, there are about 12,500 Texas children for whom the state serves as "parent." (The average number of children in conservatorship of TDHS at any time is 8,700 and the average number in TYC custody is 3,800.) The majority of these children have been abused or neglected and are not receiving full and sufficient treatment services.

Need for Multi-Agency Programs

Cooperative planning and funding for the implementation of multiagency programs will lead to the most effective treatment of child abuse and neglect victims. Although the private sector may be able to provide such treatment services to many children and families in need, the greatest demand for identification, intervention, rehabilitation, and treatment falls upon the five major state agencies serving children.

The Joint Study Committee on the Treatment of Child Abuse has been a concerted, continued, and cooperative effort of the five agencies to address the issue of child abuse and neglect. The committee has concluded that the problem is extensive, and the most effective methods for dealing with the problem, in terms of cost and treatment, require joint agency efforts. The committee has also identified a number of barriers to interagency cooperation, and, in its recommendations, incorporates this knowledge in ways that will promote more agency coordination.

The present lack of interagency coordination is largely due to the lack of funds and other resources and mechanisms by which to serve the needs of abused and neglected children. The committee is therefore requesting funds and recommending methods by which more effective treatment of child abuse and neglect can be provided through the networking of state and local resources.

Understanding Different Agencies' Perspectives

In addition to the lack of adequate resources, another barrier to providing effective services is the different perspectives of the state agencies that serve these children. At least three different perspectives are identifiable.

The *social work or psychotherapeutic model* focuses on changing behavior. It is based upon a greater awareness of the human condition and desire for change. The social work model views child abuse and neglect as indicative of parenting deficits for which both the perpetrator as well as the victim require treatment services. The social work model recognizes the positive meaning of the parent to the child and the need for treatment services to address ongoing relationships and to encourage behavior changes.

The *correctional model* focuses on changing behavior from the perspective of limiting the rights of the perpetrator, thus increasing the desire to change. The *law enforcement model* views child abuse and neglect as a crime that requires a remedy through the juvenile or criminal justice systems.

These differing perspectives cause difficulties in coordinating services across agencies. The Joint Study Committee has achieved a great deal of understanding about the services and limitations of each agency in providing for abused and neglected children. Such understanding must be extended to all agency personnel and continued as agencies work together to provide treatment services for victims of abuse and neglect. (At the same time, it is recognized that the purposes of agencies differ and therefore may come into conflict at times.)

Summary of Gaps Identified in the Service Delivery System

Many of the mechanisms and programs necessary for the implementation of the continuum of services model proposed by this committee are in place. However, large gaps in services are a barrier to providing the needed treatment services. The following gaps in the service delivery system have been identified:

- There is a lack of interagency coordination in providing treatment services.
- There is no uniform method of identifying and tracking child abuse and neglect victims served by various state agency systems.
- The need for treatment services has outstripped the available resources. Therefore, the majority of children who need treatment services do not receive them.
- Resources to treat all abused children in need of services are not available due to funding limitations. Many of the

needed treatment programs are offered but are not available statewide.

- Lack of resources for treatment of child abuse dictates that most services be concentrated on the most immediate and threatening situations.
- Only limited services are available for juvenile perpetrators of abuse.
- Texas already has responsibility for approximately 12,500 children at any one time (an average of 8,700 in TDHS conservatorship and 3,800 under TYC custody). These children need treatment services to help them avoid future dependence on public services.
- Personnel from the agencies working directly with children need training on the recognition, reporting, assessment, and diagnosis of abuse and neglect, as well as alternative medical and psychosocial treatments.

To begin to address the wide gaps in the delivery of services, the Joint Study Committee makes a number of recommendations in the following section.

5

Joint Recommendations

SECTION 5 CONTENTS

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The preceding sections have defined the extent of the problem of child abuse and neglect and compared current service needs to available services. Sections 3 and 4 presented a model for the cost-effective delivery of services using existing public, private, and community resources. As a starting point for the develop-

ment of an interagency and community child abuse network, this section presents the recommendations of the Joint Study Committee on the Treatment of Child Abuse. The recommendations are grouped under the following headings: interagency organization, research and evaluation, funding, priority populations, training, special studies, and multi-agency programming.

INTERAGENCY ORGANIZATION

Recommendation 1—Interagency Council. It is recommended that all of the agencies working with Texas children (i.e., TDHS, TDMHMR, TYC, TEA, and TJPC) create an Interagency Council on Child Abuse to coordinate research funding and programming for abused and neglected children.

RESEARCH AND EVALUATION

Recommendation 2—Research. It is recommended that the five state agencies working with abused children conduct research on the identification and treatment of abused and neglected children in Texas. The Interagency Council on Child Abuse will direct and expand the research efforts including, but not limited to, the issues addressed in recommendations 2a through 2e.

Recommendation 2a—Data Collection. It is recommended that effective September 1, 1989, state agencies will begin to develop a system for collecting data on children served who have been abused and neglected as defined by TDHS's management information system and corresponding data elements, with full implementation of the data collection process by January 1, 1990. In order to be able to conduct research on the problem of child abuse and neglect, it is essential to know more about the demographics of the abused population currently served by the five state agencies.

Rationale. Currently there are no uniform efforts by any state agency to collect data on the number of children who have been abused and neglected. In addition, there are no efforts to track these children through the different agencies that may serve them.

As a result, information essential for proper diagnosis and treatment may be lost or delayed. For instance, if a child identified as abused by one agency later enters the caseload of another, awareness of the history of abuse would enable early and appropriate treatment, essential to help the abused child avoid continued dependence on public services and to break the cycle of abuse.

Recommendation 2b—Sharing Information. It is recommended that state agencies have a clearinghouse for information about any new child in their system.

Rationale. Sharing information among agencies is important for the same reasons cited in support of Recommendation 2a—namely, to make available any history of abuse so that proper treatment decisions can be made as early as possible. There will be no restrictions prohibiting one state agency from sharing information on abuse and neglect with another state agency serving the same child, except where legal considerations preclude divulging names. In such cases, agencies such as TJPC will collect data that specify the number of children referred and adjudicated who have been identified as abuse or neglect victims.

Recommendation 2c—Common Definitions and Formats. It is recommended that all state agencies use the same criteria and format for collecting demographic information on abused and neglected children in the state.

Rationale. When a child is identified as having been abused or neglected, according to the Texas Family Code, this information should follow the child when she/he moves from one state agency to another. The sharing of information by all state agencies will minimize duplicate data collection and will enhance efforts to coordinate services to children across agencies.

Recommendation 2d—Evaluation of Therapeutic Outcomes. It is recommended that one of the first efforts of the Interagency Council will be to conduct a research project in Texas to determine the effectiveness of various therapies for treating child abuse.

Rationale. The effectiveness of different treatment methods for child victims, families, and juvenile perpetrators needs to be evaluated.

Agencies should document the treatment of child abuse and neglect victims—what services are being provided, for how long, and by what agency (except where prohibited by legal restrictions). This information, which should be part of the child abuse and neglect tracking system, will assist in referrals so that the agencies will know what did or did not work for a particular child.

Follow-up studies on each child served by any agency must be an integral part of this evaluation process. Follow-up services may be needed for six months to a year after a child leaves a state agency's system. An interagency case management component would be a most effective method for ensuring that these services are provided. The tracking component necessary to enhance case management is currently being undertaken by the Health and Human Services Coordinating Council's Children and Youth Services State Coordinating Committee, Tracking Subcommittee.

Recommendation 2e—Examination of Service-Delivery Model. It is recommended that a model for delivery of rehabilitative, community-based services such as the Oregon system be examined as a model for use in Texas.

Rationale. Because there are no concerted treatment efforts by state agencies to directly address the therapeutic needs of abused and neglected children, multiagency program development must be a high priority of the Council. Procedures and guidelines will be developed for determining which system may best serve the needs of child abuse victims, their families, and their communities. Policies and provisions for sharing information among agencies will be instituted and refined. Contract services among agencies, based upon current service needs and resources, will be encouraged.

Examples of model joint programs that need to be established or expanded in Texas include services for multi-problem children; a facility for sociopathic children and adolescents who do not respond to traditional treatment methods; the TJPC Challenge Grant Program; the TDHS-TDMHMR Intensive Family Service Program; TYC's Sex Offender Treatment Program; and community corrections programs, which aim to provide diversion services to children removed from the community and subsequently committed to TYC.

FUNDING

Recommendation 3—Funding for Interagency Programs. It is recommended that additional and adequate funds be provided to each agency to support interagency programs for abused and neglected children.

Rationale. The greatest dilemma in the treatment of child abuse and neglect is the enormous gap between needs and resources. Even if funding is increased, the need will still be great. Funds designated for interagency programs will enhance the coordination of expanded services. Through joint programs, children whose needs overlap different agencies can receive unduplicated, appropriate, and cost-effective treatment. Such treatment can help abused children to deal with the effects of their experiences and to avoid long-continued public dependency or later renewed demands upon public services.

A network is essential to serve children who, as a consequence of abuse, become severely disturbed or display criminal behavior. Although each agency has distinct service areas, the abused and neglected children are a shared population whose needs are not being effectively served.

Other recommendations involving funding of multiagency programs are found under the heading "Development of Multi-Agency Programming."

PRIORITY POPULATIONS

Recommendation 4—Priority System for Treatment. It is recommended that the Interagency Council on Child Abuse establish a system for deciding which children should receive the treatment services within the current state agencies' limited resources.

Rationale. The system should consider factors such as the large number of abused children already in the custody or conservatorship of the state, the severity of the abuse victim's need as judged clinically, and the identification of high-risk indicators in the child's current situation.

It is important to recognize that the state already has responsibility for about 12,500 children at any given time (an average of 8,700 in the conservatorship of TDHS and 3,800 in custody of TYC). Giving resource and treatment priority to these children is not only the *responsibility* of the state, which serves as their "parent," but also is the most *cost-effective* method to help such children avoid long-continued public dependency or later renewed demands on public services.

TRAINING

Recommendation 5—Joint Training. It is recommended that joint agency training on child abuse and neglect issues be instituted.

Rationale. The greatest training needs are the recognition, reporting, assessment, and diagnosis of abused and neglected children as well as alternative medical and psychosocial treatments. Personnel working directly with children need additional training on the early signs of emotional disturbance in children who may need psychological or psychiatric intervention.

In addition, training is needed in the following areas: (1) models of normality versus abnormality; (2) psychopharmaceutical interventions; and (3) behavior management of aggressive abused children.

A mechanism for the delivery of such training is presented in the report to the 71st Legislature from the Senate Select Committee on Juvenile Justice. The Joint Committee unanimously supports their recommendations on joint agency training.

SPECIAL STUDIES

Recommendation 6—Corporal Punishment. It is recommended that further study be conducted to review the effects of corporal punishment on children, especially children who have been physically abused.

Rationale. Physical force of any kind is abusive. Using physical punishment negates any therapeutic progress that may be made in the treatment of abused children. Non-aversive behavior management techniques can be used when disciplining children. It is especially important that these techniques be used with abused and neglected children in order to prevent further trauma and to augment treatment.

In 1988 the American Bar Association (ABA) adopted a resolution opposing corporal punishment (see Appendix I). The ABA report makes it clear that the resolution applies not only to schools but also to "juvenile facilities, child care programs, mental health facilities, and other institutions where children are cared for or educated." The report also points out that among the developed countries of the world only the United States and Great Britain have failed to abolish institutional corporal punishment of children. (Since the ABA report, Great Britain has abolished corporal punishment.)

Recommendation 7—Residential Treatment for Children in State Conservatorship. It is recommended that a study be conducted addressing the problem of children in state conservatorship who need in-patient or other residential treatment. Current law requires court commitment or consent by the child. In many instances, children who do not meet commitment criteria and refuse treatment are nevertheless in need of treatment services.

Rationale. Although other children under the age of 16 may be admitted through the consent of their parents, managing conservator, or guardian, children in the conservatorship of TDHS must consent to their own admission or be involuntarily committed.

Children who are emotionally disturbed and in need of psychiatric treatment are not usually in a position to judge what is best for themselves, either because of their mental status or their own developmental immaturity. If a child has to be involuntarily committed through court proceedings, it is often disturbing to the young child, and further aggravates the emotional problems for which help is being sought.

DEVELOPMENT OF MULTI-AGENCY PROGRAMMING

Recommendation 8—Family-based Services Project. It is recommended that funding be provided to TDMHMR, TDHS, TYC, and TJPC for the development and implementation of joint pilot projects on intensive family-based services at selected sites in Texas.

Rationale. Intensive family-based services provide an alternative to the extensive use of substitute care for abused and neglected children. These programs have reported a high success rate at costs significantly lower than foster homes and institutional care. They also avoid the social and psychological trauma created when a child is placed outside the home. This recommendation is consistent with the report to the 71st Legislature by the Senate Select Committee on Juvenile Justice.

Recommendation 9—School-based Therapy Project. It is recommended that funds be provided to develop school-based therapy groups for abused children in elementary and secondary schools, with the intent of later implementing the program statewide.

Rationale. Most abused children never receive counseling. The documented possible effects of untreated abuse and neglect include delinquency, running away, chemical dependency, suicidal tendencies, eating disorders, and a long list of other social ills reported by research.

The recommendation is consistent with the report to the 71st Legislature from the Senate Select Committee on Juvenile Justice. Appendix J offers a possible structural and funding system for providing school-based therapy.

Recommendation 10—Treatment for Juvenile Perpetrators. It is recommended that the 71st Legislature support the Sex Offender Council's report, which suggests that TYC's Sex Offender Treatment Programs be expanded, and it is recommended that the TJPC Challenge Grant Program be expanded and funds increased to assure placement of juvenile perpetrators in community-based treatment programs.

Recommendation 11—Responsibility for Juvenile Perpetrators. It is recommended that further study be conducted on assigning responsibility for services to juvenile perpetrators of child abuse and neglect.

Rationale. Recommendations 10 and 11 address the need to stop the cycle of abuse. As part of a comprehensive approach to confronting child abuse, services are needed that aim directly at abused children who in turn become abusers.

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Appendixes

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APPENDIX A

Psychiatric Problems Associated with Child Abuse

Table 1
Psychiatric Problems Reported to Be Associated with Child Abuse Symptoms and Traits

Psychiatric Problem	*Type of Abuse*			
Symptoms	*Physical*	*Sexual*	*Neglect*	*Emotional*
Poor self-esteem	X	X	X	
Suicidal	X	X	X	
Self-mutilation	X			
Guilt		X		
Cognitive disturbance	X		X	
Poor school performance	X	X	X	
Poor peer relationships	X	X	X	
Poor body image	X			
Runaway	X	X	X	
Locomotor delays				X
Temporal lobe dysfunction		X		
Decreased family interaction	X		X	
Primitive defenses	X			
Special symptoms	X			
Psychosomatic complaints		X		
Traits				
Aggressive	X		X	
Oppositional		X		
Avoidant, withdrawn	X	X	X	
Impulsive	X			
Compulsive	X			
Anxious	X	X		
Mistrustful	X	X		
Precocious	X	X		
Narcissistic		X		
Masochistic	X	X		
Decreased capacity for enjoyment	X			
Silent	X	X	X	X

From Coons, P. M. (1986). Psychiatric problems associated with child abuse: A review. In J. J. Jacobsen (Ed.), Psychiatric sequelae of child abuse. Springfield, Il.: Charles C. Thomas.

Psychiatric Problems Reported to be Associated with Child Abuse
Psychiatric Syndromes, Criminal Behaviors, Miscellaneous

Psychiatric Problem	*Type of Abuse*			
Psychiatric Syndrome	*Physical*	*Sexual*	*Neglect*	*Emotional*
Affective disorder	X	X	X	
Histrionic personality		X		
Psychosis	X	X		
Substance abuse	X	X		
Multiple personality	X	X	X	
Hysterical seizures		X		
Conversion disorders	X	X	X	
Psychosexual dysfunction		X		
Post-traumatic stress disorder	X	X		
Mental retardation	X		X	
Conduct disorder	X			
Factitial disorder		X		
Criminal behaviors				
Juvenile deliquency	X		X	
Murder	X		X	
Child abuse	X		X	
Wife abuse	X			
Rape		X		
Prostitution		X		
Miscellaneous				
Bitterness towards parents		X		
Defective moral development	X		X	
Hypnotic susceptibility	X			
Incest Pregnancy		X		
Abortion	X	X		
Psychiatric hospitalization		X		

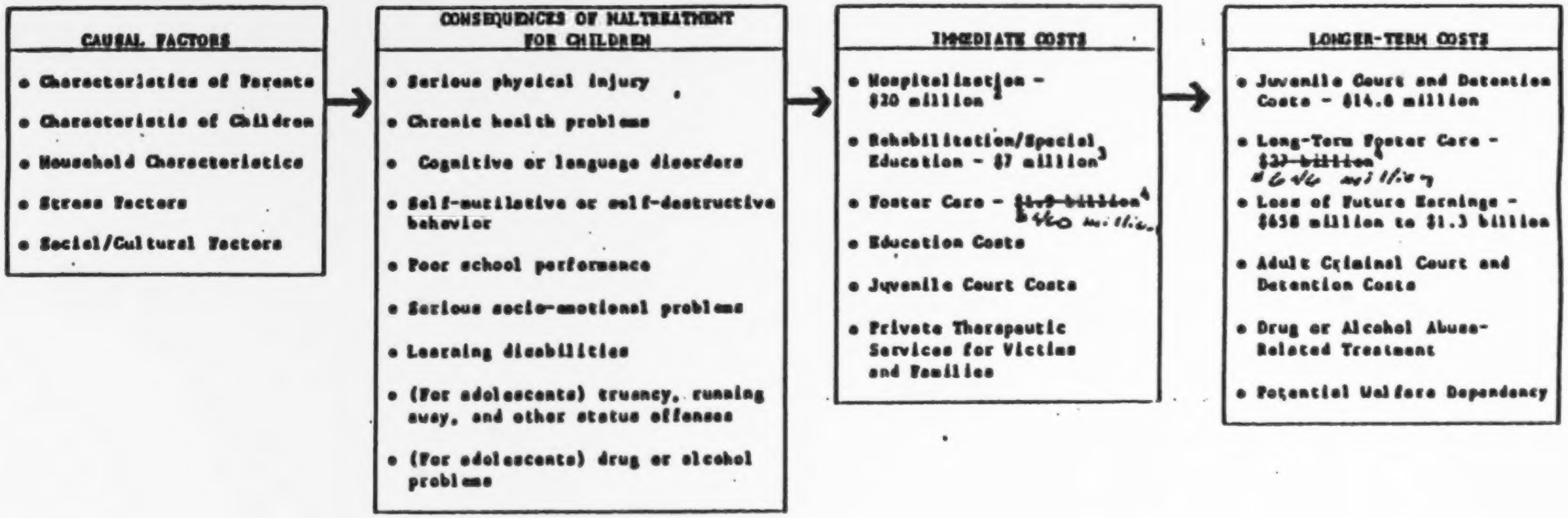
From Coons, P. M. (1986). Psychiatric problems associated with child abuse: A review. In J. J. Jacobsen (Ed.), Psychiatric sequelae of child abuse. Springfield, Il.: Charles C. Thomas.

APPENDIX B

Costs Associated with Child Maltreatment: National Estimates

Summary of the Immediate and Long-Term Costs Surrounding Child Maltreatment

(Based upon 739,000 Confirmed Cases of Maltreatment in 1983[1])



CAUSAL FACTORS

- Characteristics of Parents
- Characteristic of Children
- Household Characteristics
- Stress Factors
- Social/Cultural Factors

CONSEQUENCES OF MALTREATMENT FOR CHILDREN

- Serious physical injury
- Chronic health problems
- Cognitive or language disorders
- Self-mutilative or self-destructive behavior
- Poor school performance
- Serious socio-emotional problems
- Learning disabilities
- (For adolescents) truancy, running away, and other status offenses
- (For adolescents) drug or alcohol problems

IMMEDIATE COSTS

- Hospitalization - $20 million[2]
- Rehabilitation/Special Education - $7 million[3]
- Foster Care - ~~$1.9 billion~~[4] $460 million
- Education Costs
- Juvenile Court Costs
- Private Therapeutic Services for Victims and Families

LONGER-TERM COSTS

- Juvenile Court and Detention Costs - $14.8 million
- Long-Term Foster Care - ~~$33 billion~~[5] $646 million
- Loss of Future Earnings - $658 million to $1.3 billion
- Adult Criminal Court and Detention Costs
- Drug or Alcohol Abuse-Related Treatment
- Potential Welfare Dependency

SOURCES:

[1] American Association for the Protection of Children, Highlights of Official Child Neglect and Abuse Reporting, 1983. Denver, CO: The American Humane Association, 1985.

[2] U.S. Bureau of the Census, Statistical Abstract of the United States: 1985 (105th Edition), Washington, DC, 1984, Tables No. 171 and 172.

[3] U.S. Bureau of the Census, Statistical Abstract of the United States: 1985 (105th Edition), Washington, DC, 1984, Tables No. 231; David Braddock et al., Public Expenditures for Mental Retardation and Developmental Disabilities in the United States. Chicago: Institute for the Study of Developmental Disabilities, University of Illinois, 1985, p. 80.

[4] Charles Gershenson, "The Cost Saving Impact of Permanency Planning," Child Welfare Research Notes No. 6 (April 1984); Toshio Tatara, Characteristics of Children in Substitute and Adoptive Care: A Statistical Summary of the UCIS National Child Welfare Data Base, Washington, DC: American Public Welfare Association, 1983.

[5] U.S. Bureau of the Census, Statistical Abstract of the United States: 1985 (105th Edition), Washington, DC, 1984.

[6] U.S. Bureau of Labor Statistics, "Table of Working Life: The Increment-Decrement Method," Bulletin 2135 (November 1982), Tables 3, 7; pp. 21, 28.

	Estimated Labor Force Participation (In Years)[a]	Estimated Median Annual Earnings[b]	Number of Maltreated Children With Serious Injuries[c]	Lifetime Earnings Potential of Children	Estimated Loss of Earning Potential due to Child Maltreatment	
					Assume 5% Loss	Assume 10% Loss
Male	38.5 years	$19,708	11,564	$8,774,277,500	$438,713,850	$877,427,750
Female	27.7 years	$13,104	12,084	$4,386,259,900	$219,312,950	$438,625,990
Total/ Average	33.0 years (average)	$16,330 (average)	23,648	$13,160,537,400	$658,026,800	$1,316,053,740

[a] SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, "Table of Working Life: The Increment Decrement Method," Bulletin 2135, November 1982, Tables 3, 7, pp. 21, 28.

[b] SOURCE: U.S. Bureau of the Census, Statistical Abstract of the U.S. 1985 (105th Edition), Washington, DC, 1984, Table 700.

[c] SOURCE: American Association for the Protection of Children, Highlights of Official Child Neglect and Abuse Reporting, 1983, Denver, CO: The American Humane Association, 1985.

APPENDIX C

Residential Treatment Program

TREATMENT UNIT FOR ABUSED CHILDREN

Location:

Funding:

PATIENT SOURCES: School districts, Children's Protective Services, psychiatrists, MHMR Centers, psychologists, courts, families, etc.

ADMISSIONS CRITERIA: Child abuse causes psychiatric disorders, as well as multiple social and behavioral problems. In order to comply with JCAH standards for an inpatient unit, this unit will have to establish medical necessity as a basis for hospital admission. Disruptive behavior or social need are not sufficient to justify inpatient admission. Typical diagnoses will be: drug/alcohol abuse, borderline personality disorder, depression, conduct disorder. To meet medical criteria, a dynamic formulation should be used to assess the baseline level of psychological functioning of each patient (see attached). This assessment will be based on specific psychosocial factors and how they impinge upon mental and emotional functioning.

Legal issues must be considered for each patient: Legal status of the child, parental rights, custody, caretaker/foster parent participation in therapeutic work, role of natural parents, criminal activity, etc.

The Unit should handle children in two separate age ranges, 2-12 and 12-18. Twelve year olds may go into either group.

UNIT MAKEUP

The Unit should have three separate parts:

1. An Evaluation/Stabilization locked Sector.
2. An open hospital sector with a "stepped" program.
3. A residential sector for long term treatment.

Patients all enter through the Evaluation/Stabilization sector for 7-10 days average stay: They may return here whenever their condition warrants closer supervision.

They remain on the open hospital unit until they are ready for the less structured program in the Residential Sector. Patients may at any time return to the open or the locked unit as deemed necessary.

STAFF MAKEUP AND PATIENT/STAFF RATIO

The staff should be headed by a qualified child psychiatrist. The patient to staff ratio should be 4: 1 psych/techs. In addition, the unit must have at least 1 RN and 2-3 LVN'S at all times.

LENGTH OF STAY

Eight-16 months. Since behavior may remit without a change in psychic structure, length of stay will be determined by criteria which can be documented with changes in the dynamic formulation.

APPENDIX D

A Model of Child Abuse Treatment Services Needed

The system of treatment must be viewed in light of a primary, secondary and tertiary prevention system perspective to get a true picture of service delivery system. The different points of intervention in the diagrams are more suggestive than exhaustive of the actual number of different possible program possibilities. The key point this model makes is that there is a variety of levels of possible interventions even before treatment and these interventions enhance treatment capabilities.

The tertiary services level in which treatment works closely with protection is the main focus of the report. Treatment services alone are continually being added to through new therapeutic modalities and creative programs. The complexity of all this is vital for the different needs of different children. The salient point here becomes to decide how to prioritize and increase the number of different treatment services for different target populations of abused children.

PRIMARY PREVENTION: OUTREACH TO THE WHOLE COMMUNITY

COMMUNITY AWARENESS

- Coordinated anti-victim programs to all children in day care and school
- Media presentations: PSAs for TV, radio, newspapers; literature distribution, parenting tips in public places
- On-going inservice education of professionals and others working with children
- Community-wide information on volunteer opportunities in abuse prevention programs
- Periodic community forums and workshops
- Legislative/other advocacy for children
- Annual umbrella fundraising for local child abuse programs

SOCIAL SUPPORT

- 24 hour respite/crisis nursery
- 24 hour telephone information and referral
- Referral of comprehensive updated informal parenting resources; parent education classes, support groups, play groups, etc
- Referral of comprehensive updated formal child care services
- Neighborhood/community mutual assistance groups

PERINATAL PROGRAMS

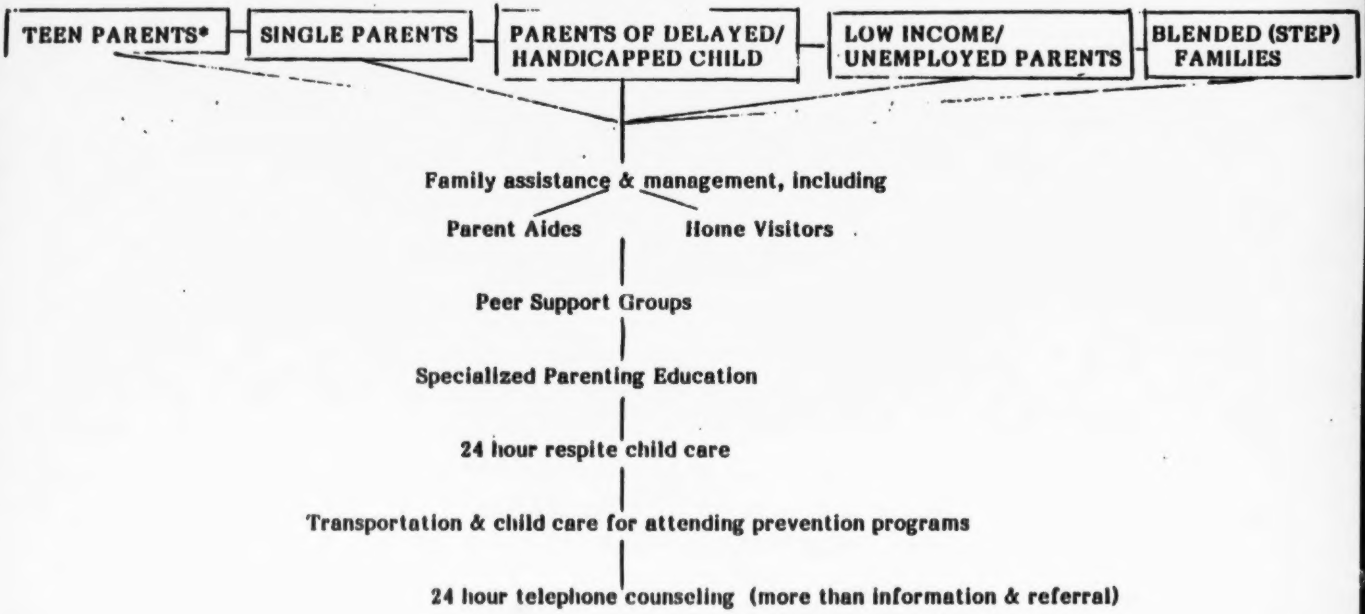
- Prenatal care by all public and private providers to include preparation for parenthood and identification of high-risk parents
- Family centered birth facilities and policies available to all
- New parent outreach by home visitation with referral and follow-up as needed

EDUCATION FOR PARENTHOOD

- Age-appropriate family life/parenting classes for all students grades K-12 as standardized components of each grade's curriculum
- Coordinated rotation of parenting education classes & workshops in places where adults naturally are; facilitated by participants' cultural peers

SECONDARY PREVENTION: OUTREACH TO HIGH-RISK GROUPS

The primary factors which make any individual or population group at higher risk for child abuse or neglect are STRESS and ISOLATION. These, especially in conjunction with LOW SELF ESTEEM and LACK OF KNOWLEDGE ABOUT ALTERNATIVE COPING MECHANISMS, can put any person at risk. However, the groups below have been identified in research literature as having a generally higher risk for maltreatment because of their higher potential for stress and isolation. Certainly this is not meant to imply that every family within these groups is likely to maltreat their child, but only that many of them are in need of special supportive services from the community.


TEEN PARENTS*
SINGLE PARENTS
PARENTS OF DELAYED/ HANDICAPPED CHILD
LOW INCOME/ UNEMPLOYED PARENTS
BLENDED (STEP) FAMILIES
Family assistance & management, including
Parent Aides
Home Visitors
Peer Support Groups
Specialized Parenting Education
24 hour respite child care
Transportation & child care for attending prevention programs
24 hour telephone counseling (more than information & referral)

*Teenage parents are underrepresented in yearly numbers of child abuse/neglect reports. More commonly they are seen later, perhaps in their 20s, when years of stress have built up and support systems may have diminished. This report would include as high-risk those persons who became parents in their teen years.

SECONDARY PREVENTION (CONTINUED): OTHER HIGH-RISK GROUPS

The following groups are unique from those previously mentioned because it is clear that all (in the case of survivors) or a significant number (those in family crisis shelters and runaways) have already experienced childhood maltreatment and are either at risk of these behaviors themselves (from learned patterns) or, if children, continue to be at higher risk for abuse.

ADULT SURVIVORS OF CHILDHOOD MALTREATMENT

- **Peer Support Groups/ Guided Self-Help**
- **Targeted Parenting Classes**
- **24 hour telephone counseling**

PERSONS IN FAMILY CRISIS SHELTERS

- **Special anti-victim, self-awareness programs**
- **Peer Support Groups/ Guided Self-Help**
- **Targeted Parenting Classes**

RUNAWAY YOUTH

- **24 hour telephone line**
- **Special anti-victim, self-awareness programs**
- **Adequate emergency shelter**
- **In-home services to identified children at risk of running away**

TERTIARY SERVICES: AFTER CHILD ABUSE HAS OCCURRED

PROTECTION

- 24 hr. abuse reporting hotline
- Public child protection agencies
- Case management: professional & lay
- Specialized investigation & prosecution
- Child Advocate/Guardian Ad Litem
- Emergency shelter
- Long-term residential care
- Foster placement programs and families
- Adoptive placement programs and families
- On-going Grand Jury education by child abuse professionals
- Multi-agency council to facilitate both public and private direct service delivery

TREATMENT

- Mobile 24 hr. crisis team for CRISIS INTERVENTION
- Victim, family and perpetrator counseling, individual and group
- Peer Support Groups/Guided Self-Help
- Medical evaluation and treatment with use of standard form by all providers
- Therapeutic day care
- School-age group treatment programs
- Therapeutic residential care for aggressive and acting-out victims
- Experienced professional counseling for adult survivors of child maltreatment
- Residential/treatment facility for perpetrators ordered out of the home (when family low-income) so that income continues to support the family
- Financial compensation to victims and families
- Interagency coordination through multi-agency council (as under protection) to facilitate referral, in-service, fundraising

APPENDIX E

Treatment Services Available in Austin - Travis County

COMPARISON OF CURRENT TRAVIS COUNTY RESOURCES TO THE MODEL

I. PRIMARY PREVENTION

COMMUNITY AWARENESS	Local Resource
Coordinated anti-victim programs to all children in day care and school	Pebble Project Child Assault Prevention Program APD "Stranger Danger"
Media presentations	Pebble Project Others
In-service education of professionals	Pebble Project Others
Annual umbrella fundraising for local child abuse/neglect organizations	NONE (currently each group primarily does its own).
Dissemination of volunteer information in local organizations	Pebble Project
Periodic community forums and workshops	Pebble Project Many others
Legislative/other advocacy for children	PTA CARE (state-wide) Others

SOCIAL SUPPORT	Local Resource
24 hour respite/ crisis nursery	NONE[a]
24 hour telephone information and referral	MHMR Hotline Warmline (currently not 24 hr.) Parents Anonymous' "Heartline" Teen Helpline (beginning Jan. 1987)
Comprehensive referral of updated informal parenting resources	NONE[b]
Neighborhood/community mutual assistance groups	MANY (Churches, clubs, neighborhood associations, etc.) But not all families have the support of such a group and are isolated.
Comprehensive referral of formal child care services	Austin Families Family Life Counseling

---

[a] Austin Emergency Shelter has respite beginning Oct. 1986, but only for families referred by Family Outreach, Center for Battered Women, and law enforcement agencies.

[b] "Parent's Guide to Austin" (a publication) and "Austin Parent" (a new magazine) contain references to some informal parenting resources.

COMPARISON OF CURRENT TRAVIS COUNTY RESOURCES TO THE MODEL

I. PRIMARY PREVENTION (CONTINUED)

PERINATAL PROGRAMS	Local Resource
Prenatal care to include preparation for parenthood and identification of high-risk	Private physicians Austin-Travis Co. Health Dept. Certified Nurse Midwives Lay Midwives Other clinics/providers[a]
Family Centered Birth facilities	4 hospital birthing centers Austin Community Birth Ctr. Certified Nurse Midwives Lay Midwives The Childbirth Connection Many preparation for childbirth classes
New parent outreach by home visitation	NONE[b]

EDUCATION FOR PARENTHOOD	Local Resource
Family life/parenting component in grades K-12	NONE[c]
Coordinated rotation of parenting education classes & workshops	Child & Family Services Seton Good Heal School Austin Child Guidance & Evaluation Ctr CEDEN Others[d]

---

[a] There are numerous prenatal care providers but no consistent provision by them of preparation for parenthood education or identification of high-risk parents.

[b] Certain agencies may provide some amount of home visitation, but there is no consistent outreach to all new parents.

[c] AISD has a two-week component offered in 7th grade Life Sciences and an elective in sr. high, but there is no county school district which includes this as part of the mandatory K-12 curriculum. Primarily it is offered only in AISD's Teen Parent Program.

[d] Many local agencies offer occasional parenting classes, but there is currently no coordinated rotation of such classes or attempt to provide them in settings where adults would naturally be found.

COMPARISON OF CURRENT TRAVIS COUNTY RESOURCES TO THE MODEL

2. SECONDARY PREVENTION

	TEEN PARENTS	SINGLE PARENTS	PARENTS OF DELAYED CHILD	LOW INCOME/ UNEMPLOYED	BLENDED FAMILIES
Family assistance/ management: PARENT AIDES & HOME VISITORS	Teenage Parent Council[a] Child & Family Service[b] Community Advocates for Teens & Parents	NONE	Assoc. for Retarded Citizens (ARC)—(Advocacy Services)	CEDEN (Parent-Child Prog.)	NONE
PEER SUPPORT GROUPS	Child & Family Service[c]	Occasionally offered through various agencies	Assoc. for Retarded Citizens (Pilot Parents)	NONE	NONE
PARENTING CLASSES	AISD Teen Parent Prog. Community Advocates for Teens & Parents	Occasionally offered through various agencies	ARC (Parenting Program) MHMR (Infant-Parent Prog)	CEDEN (Pro-Familia Prog)	Occasionally offered through various agencies
24 HR. RESPITE CHILD CARE	NONE	NONE	Capital Area Rehab[d] MHMR[e]	NONE	NONE
TRANSPORTATION & CHILD CARE TO ABUSE PREVENTION PROGRAMS	Community Advocates for Teens & Parents[f]	NONE	NONE except as mentioned under respite	NONE	NONE
24 HR. TELEPHONE COUNSELING	Heartline Warmline (not 24 hr) Teen Helpline MHMR Hotline	Heartline Warmline MHMR Hotline	Heartline Warmline MHMR Hotline	Heartline Warmline MHMR Hotline	Heartline Warmline MHMR Hotline

---

[a] "Stepping Stone" begins in 1987 as a 3-year demonstration using 1-1 lay case managers.

[b] Only one social worker in Teenage Parenting Services program.

[c] Operate only in rural Travis Co. community centers.

[d] Drop-in care but only for five hour maximum stay on weekend days and week nights.

[e] 24 hour care in foster home setting, but advance scheduling required.

[f] This service, offered by Mt. Zion Baptist Church, offers transportation & child care to teen parents in school as well as parenting classes and home visitation to a multi-ethnic clientele.

COMPARISON OF CURRENT TRAVIS COUNTY RESOURCES TO THE MODEL

2. SECONDARY PREVENTION (CONTINUED)

ADULT SURVIVORS	Local Resource	PERSONS IN FAMILY CRISIS SHELTERS	Local Resource	RUNAWAY YOUTH	Local Resource
Peer Support Groups/ Guided Self-Help	≈5 therapy groups Institute for Community-Family Treatment[a]	Targeted Parenting Classes	Center for Battered Women	24 hr. telephone line	RUNAWAY Hotline
Targeted Parenting Classes	NONE	Peer Support Groups/ Guided Self-Help	Center for Battered Women	Anti-victim, self-awareness programs	Middle Earth
24 hour telephone counseling	Heartline[b] Warmline[b] MHMR Hotline	Anti-victim, self-awareness programs	Center for Battered Women[c]	Emergency shelter	Middle Earth
				In-home services to at-risk	Middle Earth[d]

---

[a] For sexual abuse victims only.

[b] For parenting concerns.

[c] Center for Battered Women had to deny shelter to 870 children and 632 women in 1985 due to lack of space.

[d] New program to begin October 1986.

COMPARISON OF TRAVIS COUNTY RESOURCES TO THE MODEL

3. TERTIARY SERVICES

PROTECTION	Local Resource
24 hr. reporting system	State Child Abuse Hotline
Public child protection agencies	Dept. of Human Services (CPS) Austin Police Dept. Travis Co. Sheriff's Dept. Travis Co. District Attorney District & County Courts
Case management: professional & lay	DHS Child Protective Services Family Outreach
Investigation & Prosecution	Travis Co. District Attorney's Child Abuse Unit Austin Police Dept.'s Child Abuse Unit Travis Co. Sheriff
Child Advocate/Guardian Ad Litem	Courthouse Friends CASA (Court Appointed Special Advocates)
Emergency Shelter	Austin-Travis Co. Emergency Shelter Texas Baptist Emergency Receiving Home Middle Earth-Spectrum
Long-term residential care	Settlement Home Texas Baptist Residential Homes Middle Earth - Turning Point Group Home Girlstown Jr. Helping Hand Home for Children Mary Lee Schools Meridell Achievement Ctr. The Brown Schools
Foster placement programs & families	Texas Dept. of Human Services Casey Foster Placement Program Texas Baptist Foster Placement Prog.
Adoption placement programs & families	Texas Dept. of Human Services Lutheran Social Services Media support: Wednesday's Child - Channel 24 Friday's Child — Channel 7, and "Room to Spare" — Austin American Statesman
On-going Grand Jury education	District Attorney Child Abuse Unit staff Selected community experts
Multi-agency council to facilitate direct service delivery	NONE

COMPARISON OF TRAVIS COUNTY RESOURCES TO THE MODEL

3. TERTIARY SERVICES CONTINUED

TREATMENT	Local Resource
Mobile 24 hr. crisis team intervention	Austin Police Dept. Victim-Witness Assistance Prog. & Austin Rape Crisis Center provide crisis intervention, but there is no 24 hr. mobile crisis team.
Victim, family and perpetrator counseling, individual and group	Austin Child Guidance & Evaluation Center Austin-Travis Co. MHMR (DayGlo Prog.) Institute for Community Family Treatment Child & Family Services Austin Police Dept. Victim-Witness Assistance Prog.[a] Heartline (Parents Anonymous' 24 hr. telephone line) Center for Battered Women ≈ 25 experienced professional counselors[b]
Peer Support Group/Guided Self-Help	Parents Anonymous
Medical Evaluation & Treatment	Brackenridge Hospital Private physicians/other provider sites[c]
Therapeutic day care	NONE[d]
School-age group treatment programs	MHMR DayGlo
Therapeutic residential care for acting out/aggressive victims	NONE
Experienced counseling for adult survivors	≈ 25 experienced professional counselors Institute for Community Family Treatment
Residential/treatment facility for low-income perpetrators	NONE
Financial compensation to victims and families	State of Texas Victim Compensation Program
Interagency coordination through multi-agency council to facilitate all direct service providers	NONE

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[a] Limited to 3-4 sessions without supervisory extension.

[b] Many people will have financial difficulties obtaining this type of private care.

[c] There are several hospitals and many physicians in Travis Co., but no standard form for examination of suspected child abuse. Without this practitioners are wary of stating opinions.

[d] DHS funds a number of day care slots for abused children, but it is not "therapeutic" day care.

APPENDIX F

Continuum of Services: Oregon Model

Model for the Delivery of Treatment Services to Children and Families

State of Oregon

The state of Oregon provides a model for the delivery of treatment services to abused children and their families. The model

- o incorporates a continuum of care that includes prevention as well as treatment
- o draws upon existing state and community resources
- o provides for analysis of administrative and resource issues, and
- o employs a combination of treatment methods

Each regional child services division in Oregon provides treatment programs based on this model and coordinates with private, mental health, and correctional service providers in determining the needs within the region. The programs include individual, family and group therapy. Special treatment programs are offered for physically and sexually abusive families, infants, victims, non-offending spouses, and juvenile offenders.

Following are an introduction to the Oregon model, it's philosophy, and brief descriptions of Intensive Family Services, the Family Sexual Abuse Treatment Program (including non-offending spouse treatment), and a Parent Training Program. Appendix G provides a diagram of the Oregon Juvenile Sex Offender Treatment program.

For more information on the Oregon model, direct question to:

David A. Brock
Division Administrator
Protective Services for Families and Children
P.O. Box 2960 M.C. 537-W
Austin, Texas 78769
(512) 450-3653

INTRODUCTION

The family is the basic social unit of society. Families have a basic right to be free from governmental involvement. Children have a right to be raised in a safe, healthy environment. The social services offered by Child Protective Services must always be supportive of the family because the family unit is the only known effective model for nurturing and raising children. Providing for the safety and well being of children is the responsibility of the family.

Children's Services Division is designated by state law to assess reports of child abuse and neglect and assure that children are safe. The CPS process offers help to a family by first identifying factors which cause serious risk of harm to children, and then by providing services which reduce or eliminate those factors. CPS aims to help parents resolve problems which underlie child maltreatment.

Philosophy

CPS serves both the child and the family because in many ways they are inseparable. The family is usually the primary vehicle for treatment and change. Whatever strengthens or threatens a family affects the child. The objective of Child Protective Services is to protect children by stabilizing and strengthening families. CPS recognizes that it is best to keep children with their natural families when the child's safety and well being can be assured.

The primary concept for organizing and planning CPS activities is risk assessment. The most important question is whether a child is at risk of future abuse/neglect, not on whether the child has been abused. Although the latter is a vital consideration for CSD service eligibility and planning, and may be one factor among many to be evaluated, the major emphasis is to protect the child from future mistreatment by strengthening the family if needed. Consequently, there is less emphasis on defining a perpetrator or a guilty party, and more on taking steps to prevent a reoccurrence of abuse/neglect or offering services to prevent the first incident of child maltreatment in high risk situations.

Punishment of parents does little to resolve the causes of child maltreatment. Effective CPS intervention involves a non-punitive and therapeutic offer of help to a family.

Child Protective Services Case Process

The goals of Child Protective Services are:

To assure the child's welfare and safety through various protective strategies.

To maintain family unity insofar as reasonable.

To reduce those factors, causes, and stresses which led to the abuse or neglect.

To support and encourage cognitive, emotional, and behavioral adjustment which results in family maintenance or reunification.

A Child Protective Services worker enters a relationship with a family with a nonpunitive offer of help on behalf of a maltreated child. However, CPS services are often provided to families who do not voluntarily seek assistance but are reported to need help. Therefore, CPS casework has certain unique characteristics which make it different from other publicly provided social services. These characteristics include an emphasis on "reaching out" to involve children and families and dealing with resistant, and sometimes hostile, clients.

CPS has critical identification and assessment responsibilities. The administration of the duties of CPS also requires a careful balancing of the rights of parents, children, and the society at large.

Oregon law and good practice include many checks and balances on the exercise of authority by CPS. These include court reviews, administrative reviews, citizen reviews and Court Appointed Special Advocates. CPS welcomes citizen participation as important and helpful in making these difficult decisions involving families and children.

Protective services are goal oriented, time limited, and structured. They assure accountability and involvement on the part of the client, the agency, and the community. Juvenile Court services protect the child if needed, and ensure involvement of the parents in services.

The casework services delivered to children and families are accomplished with social work knowledge, methods and skills. Problem solving is a mutual effort with family members and other community professionals who work with the family.

The CPS process of helping a family involves six steps. The Practice Manual has been organized around these steps.

Screening Referrals

Assessment of Reports

Service Planning

Service Provision

Review of Progress

Case Closure

These six steps are interdependent and dynamic. For example, service provision begins with an offer of help during the initial contacts with family and risk assessment continues until the case is closed.

The field of child protective services is rapidly changing . New knowledge is emerging about abuse and neglect and more effective practice techniques are being created. This manual communicates goals of good practice and is designed to grow as child protective service practice evolves. New material will be added periodically. A Resource Handbook accompanies the CPS Practice Manual to provide supplementary information. CPS workers are encouraged to submit material for inclusion in the CPS Resource Handbook and the CPS Practice Manual.

Doing Child Protective Services is not easy. Helping families change abusive and neglectful behaviors is complex and difficult. Practitioners have an opportunity to carry out very special duties that are of great value to our society. Helping children and families to grow and thrive is a tremendous opportunity to benefit our society. No job is more important.

Oregon Children's Services Division
Family Sexual Abuse Treatment Program
1986

In 1983 Children's Services Division received legislative authorization to establish Family Sex Abuse Treatment (FSAT) programs throughout the state. These programs were charged with providing therapeutic treatment for victims and appropriate family members in situations of intrafamilial sexual abuse. The program is unique, as it is part of a child welfare agency, a natural outgrowth of child protective services, rather than mental health. Twenty programs were funded initially. Presently there are 31 county programs which provide services to all 36 Oregon counties. The program provided services to 1,333 people in 1986, from a total of 4,082 confirmed reports of child sex abuse. The Family Sex Abuse Treatment coordinators serve as treatment providers and coordinators of local community professionals who are willing to volunteer time to provide for a range of services to victims and family members. In addition to providing client services, there is an emphasis on community networking, local ownership of the problems and needs of abuse victims, and cooperation with local professionals in all disciplines who deal with issues of child abuse. There is no cost to the client for these services, unless the court has ordered an offender to pay for treatment services for the victim.

The program is designed to utilize a group treatment modality. All branches provide group treatment for victims ages 5-18 years and for non-offending spouses. Approximately 33% of the children receiving services in 1986 fell between the ages of 13-16. It is recognized that victims and other family members often need periods of individual treatment as well as family counseling. This may be accomplished through utilization of CSD resources such as Intensive Family Services, Hi-Impact, and Parent Training, or local community providers. Individual and play therapy services are generally available through each FSAT program to sexual abuse victims younger than age five.

All programs are designed to initiate services as soon as possible after disclosure and to continue through the process of clarification and reunification, if a family so desires. In cases of intrafamilial abuse the offender is generally removed from the home until offender/victim treatment providers and corrections officer agree that reunification may begin. The typical case of intrafamilial sexual abuse treatment in which reunification of the family occurs now requires 27 months of the Children's Services Division intervention and supervision prior to case closing. Constant safety and treatment progress monitoring are necessary. The length of time a family must remain in treatment and the case remain open is predicated on the predictably slow progress the perpetrator makes in treatment to alter his sexually deviant behavior patterns.

The Family Sex Abuse Treatment Coordinators are all experienced counselors who have chosen to specialize in sex abuse treatment. Each region maintains regular network meetings of the specialists to encourage the sharing of technical and resource information, treatment techniques, and to help reduce stress.

In 1987 ongoing professional case consultations will be available to all specialists, as well as specialized training opportunities. The coordinators in turn are asked to assist in protective service investigating, training other CSD staff and volunteers, and acting as expert witnesses, in addition to their program responsibilities within Children's Services Division and the community.

A statewide coordinator of the Family Sex Abuse Treatment Programs is responsible for program design, training, consultation, and enhancement of resources throughout the state to address the problem of child sexual abuse.

Treatment Services

The goals of the Family Sexual Abuse Treatment Program are to:

1. Enable resolution of the emotional trauma of the sexual abuse experience appropriate to each victim's age and developmental stage.

2. Prepare victims for self-protection from further abuse.

3. Prevent further sexual abuse within the family.

4. Eliminate the perpetrator's abuse of power and misuse of sexuality within the family.

The Family Sexual Abuse Treatment Program does not provide behavioral assessment and treatment services to the perpetrators of sexual abuse. Perpetrators must seek treatment from other public or private mental health therapists. Under ORS 184.807,perpetrators are now required to pay the treatment costs of their own, their victim's, and other appropriate family members' therapy.

The treatment components of the Family Sexual Abuse Treatment Program are based on the premise that the offender is solely responsible for the victimization of the child. Court jurisdiction to clearly place responsibility for the abuse with the offender and to assist offenders to receive the treatment necessary to control their behavior are important parts of a community response to sexual abuse. The highly structured and technical treatment of sexual offenders is by and large conducted by private practitioners throughout the state. Most communities maintain community treatment teams which allow for close coordination between treatment providers.

Victim Group Treatment

Group therapy for the child and adolescent victims of intra-family sexual abuse is the treatment of choice in the thirty-one Family Sexual Abuse Treatment Programs. Group members are helped to overcome their sense of isolation and fears of deviancy by sharing with peers the sexual abuse experience, the court process, and the consequences of family disruption as a result of the disclosure. Sharing experiences enables victims to approach subjects they might otherwise find psychologically overwhelming: feelings of low self-esteem and "damaged goods syndrome"; suicidal thoughts; awareness of maternal competition, anger, or jealousy; feelings of exploitation of normal needs for affection and for nurturing;

feelings of sexual confusion; loss of the idealized sense of self and family; and, the reality of parents who have a limited capacity for change.

The predominant feelings of child and adolescent victims of sexual abuse are an intermix of guilt, anger, sadness, anxiety, alienation, ambivalence, and grief.. The identification and expression of these feelings is the focus of victim therapy in both boys and girls groups. The treatment groups emphasize that child and adolescent victims are not responsible for the sexually abusive acts of adults. The group curriculums teach safety, assertiveness, anger management, personal rights, self-worth, and sex education as effective means toward the resolution of the sexual abuse experience.

Non-Offending Spouse Treatment

It is recognized that non-offending spouses play a critical role in trauma resolution for the victim. Every effort is made to engage the non-offending spouse in treatment as soon as possible. The goals of treatment for non-offending spouse are:

1. To develop an awareness of the dynamics of her own individual experience and that of her child, so responsibility for lack of protection and communication can be clarified to the victim.

2. To understand the nature of the offender's thinking errors and behavior cycles.

3. To demonstrate self-esteem, assertiveness, and problem solving behaviors that indicate an ability to protect her children and to care for herself.

4. To develop communication skills and system of support through group sharing and information.

Program Results

The FSAT programs provided treatment to 1,333 individuals, from a total of4,082 reports of child sexual abuse. Approximately 37% of the services were to adults and 63% to children. The average length of time services were provided was just under five months. In 250 cases, services were initiated in less than 30 days from date of assessment.

Regional Distribution of FSAT
Services Opened in 1986

Region I	266
Region II	422
Region III	349
Region IV	264

Average Length of Treatment

The length of stay in victim treatment groups ranged from 1 day to 14.8 months. The average length of stay per child in treatment in 1986 was 144 days. The average treatment period for adults was 135 days.

Successful Outcomes

There were 1,046 terminations from treatment that opened in 1986 and closed by April 1, 1987. This indicates a significant increase over the 232 cases terminated in 1984. Of these, 534 persons had at least partially resolved the emotional trauma accompanying the sexual abuse experience. For these victims there is a markedly reduced risk of further abuse and of victim patterns continuing into adulthood, perpetuating behavioral patterns which result in generation sexual abuse.

Non-Successful Outcomes

Of the 1,046 service terminations, 146 were identified as having "no changes." Of the cases where there was no change, 27 remained in the program less than one month.

Future Goals

Next year the FSAT program will review and revise its program guidelines to reflect the changes that have been occurring in the field of child sexual abuse treatment. The demands on the FSAT programs have increased dramatically as more adults molested as children (often parents of victims), male victims, and sexually aggressive youth are being identified, in addition to the increase in female child victims. More individualized treatment planning on the local level, resource development and coordination on both the local and state level is expected to occur. Better tracking of victims and families and assessing the effectiveness of our interventions are additional goals.

Observations Concerning a Child Abuse Service Model
Family Sexual Abuse Treatment Program
Oregon Children's Services Division

Goals of the Program:

1. Enable resolution of the emotional trauma of the sexual abuse experience appropriate to each victim's age and developmental stage.

2. Prepare victims for self protection from further abuse.

3. Prevent further sexual abuse within the family.

4. Eliminate the perpetrator's abuse of power and misuse of sexuality within the family.

Unique Features of the Program:

1. The Treatment Program is administered by the Child Protective Services Agency rather than State Department of Mental Health.

2. In addition to providing client services there is an emphasis upon:

   a. community networking
   b. local responsibility for dealing with the problems and needs of abuse victims.
   c. cooperation with local professionals in all disciplines who deal with issues of child abuse.

3. The program does not provide behavioral assessment and treatment services to the perpetrators of sexual abuse. Perpetrators must seek treatment from other public and private mental health therapists.

4. Group therapy is the treatment of choice. The curriculum for the group teaches safety, assertiveness, anger management, personal rights, self worth and sex education as effective means toward resolution of the sexual abuse experience.

5. Non-offending spouses are engaged in treatment as soon as possible because of the critical role they play in the trauma resolution for the victim.

6. The service is provided at no cost to the victims and the non-offending members of the family. Perpetrators are required to pay the treatment costs of their own, and when court ordered, those of their victim and other appropriate family members engaged in therapy.

SAMPLE OUTLINE

ANNUAL REPORT OF FSAT PROGRAM

BRANCH

Name(s):

FTE:

Supervisor:

Date:

I. TREATMENT GROUP ORGANIZATION

Include:

A. Types and nature of groups (who served?, time limited?, educational/treatment focus?, etc.)

B. Co-facilitators

C. Duration

D. Numbers in group at time of report

E. Any particular problems, issues, etc.

II. ADJUNCTIVE TREATMENT SERVICE (Provided by FSAT)

A. Crisis services

B. Individual/family services

C. Investigative services

D. Any other (i.e., expert witness)

E. Problems, issues

III. PUBLIC AWARENESS ACTIVITIES

A. Public speaking activities (How often? To whom? Who does this?)

B. Fund raising (if any)

C. Publications (if any) - please attach

IV. INTERAGENCY ROLE

A. Do you have interagency team meetings? Who coordinates these meetings?

B. How often do you meet with other agencies?

C. Does the school district have personal safety curriculum?

D. What are the other lead agencies or providers in sex abuse service delivery network in your county?

E. List treatment resources and services available locally.

F. Any special problems/issues with other agencies or providers.

V. INTRA AGENCY ROLE

A. Describe role of FSAT (coordinator? treatment provider?)

B. Describe the client process for receiving FSAT service (From intake through referral, assessment, treatment, treatment reviews, termination of services)

C. Describe interoffice communication system; i.e., are verbal reports given every 60 days, written every 90? Do you meet with the units?

D. Is fee collection taking place? If so, by whom?

E. What is role of supervisor? Co-leads groups? Provides consultation?

VI. GOALS FOR FSAT PROGRAM

A. Long Term

B. Short Term

FACT SHEET

INTENSIVE FAMILY BASED SERVICES

Home based family centered service programs reflect the principle that the first and greatest investment should be made in the care and treatment of children and their families in their own homes. Funds, personnel, and other resources are expended, not on one family member in placement, but on the family unit.

Intensive Family Based Services provide an alternative to the extensive use of substitute care for abused/neglected children and others who are at risk of placement. These include the following:

1. Status offenders and minors adjudicated delinquent
2. Families of emotionally disturbed children or parents
3. Families of adolescents in conflict with family and community.

These programs have reported a high success rate at costs significantly lower than foster home and institutional care. They also avoid the social and psychological trauma created when a child is placed outside the home.

Intensive Family Based Services are characterized by the following:

1. A primary worker or case manager establishes and maintains a nurturing, supportive relationship with the family.

2. Small caseloads, staff availability and the utilization of a wide variety of helping options.

3. One or more associates serve as team members or provide backup for the daily worker and may meet regularly with the worker and the family.

4. Staff availability twenty-four hours a day, seven days a week, often serving as extended family.

5. The family home is the service setting, and includes problem solving efforts in the family's ecological system. This may involve the school, police, employers, housing authorities, etc.

6. Service is as complete, comprehensive, and intensive as is necessary to effect problem resolution.

7. Maximum utilization of family resources, extended family, and community. Workers quickly discover and build on strengths in families, even the most problematic families.

8. Provision of help with any problem presented. If the team does not have the expertise or resources needed, it arranges for or creates them in order to stabilize and improve family functioning.

9. The parent remains in charge of his/her family, as educator, nurturer, and primary care provider. Parents are often given renewed relevance and participate in setting program priorities, planning, and decision making.

CHILDREN'S SERVICES DIVISION PARENT TRAINING SERVICE

AN OVERVIEW:

The CSD Parent Training Service is currently serving 27 CSD branches statewide through the work of 19 masters level trainers.

The goal of the program is to enable families whose children are at risk of experiencing substitute care due to abuse, neglect or delinquency to retain or regain their children in their own homes. The historical practice of removing these children to various forms of substitute care has more often than not been costly both in terms of human suffering and in terms of tax dollars. The Parent Training Service is designed to enable families to gain the parenting knowledge and skills they need to work effectively with their own chidren. Together with the Intensive Family Service and Homemaker programs employed in various CSD branches, the PTS has been successful in significantly reducing the number of children removed from their homes to substitute care facilities over the last three years.

THE FORMAT:

Parents are referred to the PTS by CSD caseworkers, based on their evaluation of clients' needs. Following referral, an assessment of parenting skills is done by the Trainer, preferably in the clients' home. This assessment is designed to pinpoint areas of need, and together with an interview of the parents and an observation of the children form the basis for placement of the family in one of three possible parent training formats available in most branches. Skill groups are the main format utilized to convey the skills covered by the curriculum. These weekly sessions are highly structured, experiential and last about 2 hours. To afford parents in-home practice of the behavior management skills taught in these groups, the Homemaker (or the Parent Trainer, where Homemakers are not available) works with an individual family in their own home to provide skills between sessions. Support groups are designed to augment skill groups with an opportunity for personal discussion and peer support. Child care and transportation are provided for both types of groups. For clients who are not yet ready for group training, one-on-one in-home training is available as a first step in preparing families for group sessions.

THE CURRICULUM:

The curriculum is designed specifically for CSD clients and is based on a combination of therapeutic and instructional approaches. The curriculums are organized into three separate packages depending on the age of the target child. Because it is often difficult for Trainers to organize groups which segregate parents by children's ages in this manner, the curriculum is also organized so that units of the same title can be combined across age designations. Trainers can, for example, pull materials from "Behavior Management 0-3 years" together with materials from "Behavior Management 4-12 years" so that they can teach a group of parents whose children span both of those age ranges. Sessions are highly structured but utilize concrete learning experiences and do not rely on a middle class frame of reference, or on reading or writing skills. Skills are taught primarily through short explanations followed by experiential and affective exercises. Simple language and concrete applications are emphasized. The curriculum is self-contained: session plans are outlined inclusive of time frames; all necessary background material for Trainers, all experiential exercises and client materials are appended behind each session plan.

PTS CORE CURRICULUM UNITS

PARENTS OF CHILDREN 0-3 YEARS		PARENTS OF CHILDREN 4-12 YEARS		PARENTS OF ADOLESCENTS	
Unit Title	Sessions (Weeks)	Unit Title	Sessions (Weeks)	Unit Title	Sessions (Weeks)
"Taking Care of Yourself"	*5*	*"Taking Care of Yourself"*	*5*	*"Taking Care of Yourself"*	*5*
"Bonding"	*4*	*"Behavior Management"*	*5*	*"Developmental Issues: Adolescence"*	*3*
"Behavior Management"	*4*	*"Developmental Issues: 4-12"*	*4*	*"Building New Relationships"* *	*6*
"Developmental Issues: 0-3"	*4*	*"Communication"**	*4*	*"Regaining Control"*	*2*
"Anger Management"	*7*	*"Anger Management"*	*7*	*"Anger Management"*	*7*
Total Sessions	*24*	*Total Sessions*	*25*	*Total Sessions*	*23*

**This unit is considered an optional or second-level offering.*

The listing on the preceding page is an outline of curriculum contents. Most parents do not experience all units nor do they typically proceed in the order listed above. The units are offered on a rotating basis, and are non-sequential so that parents may be referred in at any point and may complete a cycle from whatever time they begin. Each session is designed to key on a specific skill. Evaluation of the degree to which these skills have been integrated by parents into their daily routine with children is assessed upon termination, utilizing behavioral observation and/or interview.

APPENDIX G

Model Treatment Program for Juvenile Sexual Offenders

GUIDELINES FOR TREATMENT OF JUVENILE SEXUAL OFFENDERS

LEVELS AND DURATION OF TREATMENT	CLIENT/SITUATION PROFILE	ASSESSMENT, STANDARDS, AND OPTIONS	INDIVIDUAL THERAPY	FAMILY THERAPY	ADOLESCENT GROUPS
1. **COMMUNITY-BASED TREATMENT** emphasis on education *4-16 weeks*	1. Preadolescent 2. No previous history of acting-out behavior 3. Adequate social skills and socialization 4. Lack of sexual knowledge and experience 5. Sexual events isolated, opportunistic, exploratory, situational, non-violent with younger children 6. Adjudication optional 7. Safe to treat in community	1. Child interview 2. Parent interview 3. Appropriate psychological screening 4. O'Brien typology 5. Police reports	2-3 sessions (assess for prior victimization)	Weekly for 1-6 months	4-12 sessions; covering: 1. Support 2. Human sexuality 3. Victim empathy 4. Offender responsibility 5. Behavioral cues to offense
2. **COMMUNITY OUTPATIENT PROGRAM** offender in own or foster home *6-18 months*	1. Poor social skills 2. No history of other serious acting-out behaviors 3. Low self-worth 4. Sexual behavior with younger children effected through manipulation, enticement, entrapment 5. Must admit to offense 6. Adjudication highly desirable 7. Safe to treat in community,	1. Child interview 2. Parent interview 3. Approporate psychological evaluation and tests 4. O'Brien typology 5. Police reports 6. Polygraph (optional) 7. Plethysmograph (optional)	As indicated; issues to include: 1. Prior victimization 2. Sexual identity 3. Empathy 4. Deviant fantasies	Weekly for 6-18 months as appropriate	2 hours weekly for 16 weeks; covering: 1. Social skills training 2. Human sexuality 3. Thinking errors 4. Anger management 5. Stress cycles 6. Communication skills 7. Substance abuse 8. Victim empathy 9. Assertiveness 10. Values 11. Prior victimization 12. Journal
3. **DAY TREATMENT PROGRAM** maximum community safety with parents and care providers supervising offender while in least restrictive setting *6-18 months, treatment up to 12 hours a day, supervised 24 hours a day*	1. Needs structured treatment yet capable of maintaining while living in community 2. Responsibility for crime must be acknowledged (especially if moving from a more secure placement) 3. Needs a viable family for support and supervision 4. Wide range of sexual offenses committed, from child molestation to rape 5. Adjudication necessary	Ongoing, including: 1. Psychological 2. Medical 3. Family and social history 4. Sexual offending behavior and risk 5. Reports from previous programs 6. Police reports 7. Polygraph (optional) 8. Plethysmograph (optional)	As indicated; covering: 1. Prior victimization 2. Sexual identity 3. Empathy 4. Deviant fantasies 5. Offender responsibility 6. Understanding responsibility 7. Understanding etiology and empathy	Parent or substitute parent involvement required weekly for 6-18 months	2 hours weekly for 16 weeks; covering: 1. Social skills training 2. Human sexuality 3. Thinking errors 4. Anger management 5. Stress cycles 6. Communication skills 7. Substance abuse 8. Victim empathy 9. Assertiveness 10. Values 11. Prior victimization 12. Journal 13. Thinking errors and cycles: focus on recognizing own errors, cycles, and cognitive change 14. Apology to victim (often symbolic)

Guidelines for Levels 1,2,3 (Continued)

LEVELS AND DURATION OF TREATMENT	PARENT GROUPS	ALCOHOL AND DRUG STRATEGY	BASIC EDUCATION	COMPLIANCE AND CONTROL LEVEL	WORK AND RECREATIONAL ACTIVITIES	AFTER CARE	PROGRAM EVALUATION
1. **COMMUNITY-BASED TREATMENT** **emphasis on education** ***4-16 weeks***	4-12 sessions; covering: 1. Support 2. Human sexuality 3. Victim empathy 4. Offender responsibility 5. Behavioral cues to offenses	Assess and refer as needed	Awareness of learning problems which may affect treatment participation	If problematic refer to more intensive level of treatment	Not applicable	None	Essential to evaluate success of program through post-testing and follow-up
2. **COMMUNITY OUTPATIENT PROGRAM** **offender in own or foster home** ***6-18 months***	16 weeks; covering: 1. Support 2. Human sexuality 3. Victim empathy 4. Offender responsibility 5. Patterns of offending behavior 6. Communication skills 7. Parenting skills	Assess and refer as needed	Awareness of learning problems which may affect treatment participation	If problematic refer to more intensive level of treatment	Not applicable	2-12 months in support group	Essential to evaluate success of program through post-testing and follow-up
3. **DAY TREATMENT PROGRAM** **maximum community safety with parents and care providers supervising offender while in least restrictive setting** ***6-18 months, treatment up to 12 hours a day, supervised 24 hours a day***	16 weeks; covering: 1. Support 2. Human sexuality 3. Victim empathy 4. Offender responsibility 5. Patterns of offending behavior 6. Communication skills 7. Parenting skills	Assess and refer as needed plus alcohol and drug education	1. Daily classes within day treatment setting (minimum 3 hours per day) 2. Teachers part of treatment team	1. Positive peer culture 2. Meetings with parents, youth, and parole officer when necessary 3. Suspension or expulsion	1. Daily recreation 2. Link with vocational education, especially at transition	1. 6 months in family therapy 2. Transition group 3. Individual contract	Essential to evaluate success of program through post-testing and follow-up

GUIDELINES FOR TREATMENT OF JUVENILE SEXUAL OFFENDERS

LEVELS AND DURATION OF TREATMENT	CLIENT/SITUATION PROFILE	ASSESSMENT, STANDARDS, AND OPTIONS	INDIVIDUAL THERAPY	FAMILY THERAPY	ADOLESCENT GROUPS
4. **GROUP HOMES AND CHILD CARE CENTERS** 24-hour residential, community-based care *12-18 months*	1. Poor social skills 2. Low self-worth 3. Sexual behavior with younger children effected through manipulation, enticement, entrapment 4. Moderate coercion used in offenses 5. Dysfunctional family; unable to supervise offender, supports denial, enables defensive behavior 6. History of delinqency 7. Adjudication desirable	Ongoing; including: 1. Psychological 2. Medical 3. Family and social history 4. Sexual offending behavior and risk 5. Reports from previous programs 6. Police reports 7. Polygraph (optional) 8. Plethysmograph (optional)	Weekly sessions as indicated; covering: 1. Prior victimization 2. Sexual identity 3. Empathy 4. Deviant fantasies 5. Offender responsibility 6. Understanding responsibility 7. Understanding etiology and empathy	When possible	Same as Day Treatment Program, above
5. **TRAINING SCHOOLS** secure, locked environment *3-6 months*	1. Extensive history of delinquency 2. Mixture of incest, non-incest offenses 3. Failure in community-based programs 4. History of running away 5. Chaotic family, including much violence 6. Adjudication necessary	1. Psychological 2. Medical 3. Adjudication records and offender's admission 4. Police reports 5. Victim's statements 6. Sexual histories 7. Autobiographies 8. Polygraph (optional) 9. Plethysmograph (optional)	As indicated; covering: 1. Self-worth 2. Victim empathy 3. Intervention	When possible (return home based on *family* cooperation); monthly workshops available for parents	Ongoing; covering: 1. Improving self-concept by improving skills and exploring thinking errors 2. Ownership of offense 3. Disclosure 4. Responsibility 5. General readiness for community-based treatment
6. **SECURE UNITS** offender unsafe in community settings; staff carefully selected and matched with offender; positive peer culture utilized *6-24 months*	1. Force or violence used in commission of sexual assaults against peers, adults, or children 2. History of numerous anti-social, acting-out behaviors 3. Denial and projection are primary defenses 4. Sexual victimization in childhood probable 5. Feels inadequate, helpless; often uses anger as a major affective mode 6. Poor impulse control 7. Rigid value system 8. Dangerous to self or others 9. Psychiatrically disordered 10. Adjudication necessary	1. Psychological 2. Medical 3. Adjudication records 4. Reports from previous community programs 5. Community planning input 6. Police reports 7. Psycho/social histories 8. Psychiatric evaluation 9. Polygraph (optional) 10. Plethysmograph (optional) 11. Sexual Card Sort (assess treatment readiness) (optional)	Individual treatment plans with variety of treatment modalities; may include art therapy and hypnosis; covering: 1. Prior victimization 2. Sexual identity 3. Empathy 4. Deviant fantasies 5. Offender responsibility 6. Understanding responsibility 7. Understanding etiology and empathy 8. Relaxation 9. Discharge criteria	Essential if youth returning home; coordinated by outreach staff; may be a contracted community program	Daily unit groups with: 1. Peers leading, setting agenda, etc. 2. Leaders using social reinforcers 3. One offender each day as focus of group 2-3 daily small groups focusing on inter-personal skills Weekly treatment groups; covering: 1. Social skills training 2. Human sexuality 3. Thinking errors 4. Anger management 5. Stress cycles 6. Communication skills 7. Substance abuse 8. Victim empathy 9. Assertiveness 10. Values 11. Prior victimization 12. Journal 13. Thinking errors and cycles: focus on recognizing own errors, cycles, and cognitive change 14. Apology to victim (often symbolic) 15. Police reports 16. Life history written and approved by group 17. Role-playing offenses, including reversals

Guidelines for Levels 4,5,6 (Continued)

LEVELS AND DURATION OF TREATMENT	PARENT GROUPS	ALCOHOL AND DRUG STRATEGY	BASIC EDUCATION	COMPLIANCE AND CONTROL LEVEL	WORK AND RECREATIONAL ACTIVITIES	AFTER CARE	PROGRAM EVALUATION
4. GROUP HOMES AND CHILD CARE CENTERS 24-hour residential, community-based care *12-18 months*	1 1/2 hours per week for 12-18 months; covering: 1. Support 2. Human sexuality 3. Victim empathy 4. Offender responsibility 5. Patterns of offending behavior 6. Communication skills 7. Parenting skills	Alcohol and drug group in-house or in conjunction with alcohol and drug programs	1. On-campus school 2. Transition to public school	1. Positive peer culture 2. Behavioral levels 3. Termination from program if not involved in group or stuck in denial	Structured, supervised community activities	Local system; transition to increasing independence	Essential to evaluate success of program through post-testing and follow-up
5. TRAINING SCHOOLS secure, locked environment *3-6 months*	Workshops monthly around the state	Educational curriculum of alcohol and drug abuse unit shared with sex offenders (provided in conjunction with alcohol and drug liaison)	Self-contained classroom separate from other offenders (sex education included in curriculum)	Disciplinary environment: 1. Self-contained 2. Secure 3. Structured	Variety of physical, work, and vocational activities	Transition to community-based programs for ongoing treatment	Essential to evaluate success of program through post-testing and follow-up
6. SECURE UNITS offender unsafe in community settings; staff carefully selected and matched with offender; positive peer culture utilized *6-24 months*	Desirable	1. Weekly group based on Alcoholics Anonymous model with Alcoholics Anonymous after-care 2. Alcohol and drug education	1. Self-contained classrooms 2. Teachers part of treatment team	1. Positive peer culture 2. Individually signed contracts used as leverage	Therapeutic recreational programs	Direct after-care as appropriate or refer to private or community program	Essential to evaluate success of program through post-testing and follow-up

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APPLENDIX H

History of State Agency Involvement In Child Abuse Issues

CHRONOLOGY OF EVENTS SHOWING STATE AGENCIES INVOLVEMENT WITH THE TREATMENT AND CARE OF ABUSED CHILDREN AND ADOLESCENTS

1836 - Texas established the common law of England for the prosecution of all crimes and misdemeanors. Youth under age seven were not punished for crimes and misdemeanors. Those over age seven were treated as adults.

1850 - Adoptions were known following legislation.

1856 - The Texas Legislature raised the age of criminal responsibility to age nine. For those who lacked discretion necessary to understand the nature of his act, the age was thirteen.

1856 - The Texas Legislature passed a statute forbidding the death penalty for youth under age 17.

1856 - Deaf and dumb asylums were established. In the next few years institutions for the blind, lunatics and orphans were also established.

1887 - The Texas Legislature appropriated funds for the Gatesville reformatory.

1907 - The Texas Legislature enacted the Texas Juvenile Act which defined dependency and neglect and allowed court-appointed guardians of neglected children.

1909 - The White House Conference on Children recommended new programs to care for mentally ill children.

1913 - The Texas Legislature authorized the Gainsville State School for girls.

1919 - The Texas Legislature established the Waco State Home for dependent and neglected children.

1931 - The Division of Child Welfare was created by the Texas Legislature as part of the Board of Control which began statewide intervention.

1939 - The Division of Child Welfare was transferred to the newly created Texas Department of Public Welfare. Federal, state and county participation in services for abused and neglected children increased gradually over the next three decades.

1949 - The Board of State Hospitals and Special Schools was established. It became the Texas Department of Mental Health and Mental Retardation in 1965.

1949 - The Texas Youth Development Council was established. It became the Texas Youth Council in 1957, and later, the Texas Youth Commission.

1949 - Texas Education Agency was established by the Gilmer-Aikin law.

1957 - The Texas Youth Council was created.

1962 - The Social Security Act was amended to require a statewide system of Child Protective Services.

1965 - The Texas Department of Mental Health and Mental Retardation was created.

1969 - Title IV-B of the Social Security Act was enacted requiring child protective services statewide.

1974 - The newly created Texas Family Code gave the Department of Public Welfare more responsibility for services to abused and neglected truant and runaway children. The code also made it a misdemeanor in Texas to fail to report suspected abuse or neglect of children.

1974 - Federal dollars became available so that the Department of Public Welfare could contract for treatment services within the community.

1975 - A statewide Public Awareness campaign on the new reporting laws resulted in a 200% increase in reports of suspected child abuse and neglect received the previous year. Texas joined the interstate compact on the placement of children.

1975 - The United States Legislature enacted a bill guaranteeing children with handicapping conditions the right to an appropriate free education.

1976 - The Office of Juvenile Justice Act was amended to order the deinstitutionalization of status offenders.

1977 - The Texas Department of Public Welfare became the Texas Department of Human Resources.

1979 - The Department of Human Resources established an intake priority system to manage increasing numbers of abuse and neglect reports.

1980 - The Office of Juvenile Justice Act was amended to remove children from adult jails.

1981 - Federal reduction in Title XX funding resulted n eliminating services to children who were not abused or neglected but for whom prevention services had previously been available.

1981 - The Texas Juvenile Probation Commission was created.

1983 - Juvenile Probation Departments were created in all Texas counties.

1985 - The Texas Legislature established the Children's Trust Fund to support community-based prevention programs throughout Texas.

1985 - Final deadline for total jail removal of juveniles from adult jails.

1985 - The Texas Department of Human Resources became the Texas Department of Human Services.

1985 - House Bill 986 was passed requiring all school districts in Texas to provide in-service training to enable educators to recognize and report suspected abused and neglected children.

1987 - The Texas Legislature enacted statutory definitions of child abuse and neglect.

1987 - House Bill 986 requiring child abuse training for educators was repealed by the 70th Legislature.

APPENDIX I

American Bar Association Report
Corporal Punishment

American Bar Association

TO : Organizations and Individuals interested in the ABA's new policy related to the abolition of corporal punishment in schools and other institutions

FROM : Howard Davidson, Director, ABA National Legal Resource Center for Child Advocacy and Protection

DATE : July 18, 1985

I am pleased to forward to you a copy of a resolution which was just adopted by the American Bar Association's House of Delegates, thus making it the official policy of this Association.

The resolution was brought before the ABA's policy-making body by the Association's Family Law Section and Individual Rights and Responsibilities Section. It was also endorsed by the ABA Young Lawyers Division, which sponsors our Child Advocacy Center program.

The approved policy was carefully crafted to meet the expected criticisms of those attorneys who are sensitive to the need for order and safety in schools and other institutions, while it clearly stands for the principle that state laws should prohibit corporal punishment (defined in the attached Report as "the infliction of pain (or unnecessary excessive discomfort)...upon the body...as a penalty for doing something that has been disapproved of by the punisher"). The Report also makes it clear that the resolution applies not only to schools, but also to "juvenile facilities, child care programs, mental health facilities, and other institutions where children are cared for or educated".

This important policy step for the Association advances upon earlier resolutions related to child abuse, foster care, children with learning disabilities, and the enhancement of child care resources for American families. These are all issues with which our Center is involved.

I welcome your suggestions on what action the ABA might now take to have this new resolution result in appropriate state legislation and other policies which will bring about the intended end of institutional corporal punishment.

A Program of the
Young Lawyers Division

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RESOLUTION OF THE HOUSE OF DELEGATES

OF THE

AMERICAN BAR ASSOCIATION

ADOPTED JULY, 1985

BE IT RESOLVED, that the American Bar Association opposes the use of corporal punishment in institutions where children are cared for or educated and urges that state laws which permit such corporal punishment be amended accordingly.

BE IT FURTHER RESOLVED, that the Association does not oppose such force as is reasonable and necessary to quell a disturbance threatening physical injury to persons or property, to protect persons or property from physical injury, to remove a child causing a disturbance who refuses to cease or to leave when so ordered by the authority, or to obtain possession of weapons or other dangerous objects upon the person or within the control of the child. In addition, the use of accepted educational techniques and treatment approaches used as behavior modification for seriously disabled children does not constitute corporal punishment.

REPORT *

The ABA already has policy which either explicitly or implicitly prohibits corporal punishment of adult or juvenile offenders. It appears inappropriate for children who have not been accused of any crime to fail to receive the same bodily protections.

This report argues that institutional corporal punishment of children should be considered as a form of child abuse that is contrary to current knowledge of human behavior and sound educational practices. It is also generally agreed by educators, doctors, social workers and others that institutional corporal punishment of children is unnecessary and that alternative methods of maintaining institutional discipline are more effective.

In 1979, the comprehensive Standards Related to Schools and Education was recommended by the Institute of Judicial Education-American Bar Association, Joint Commission on Juvenile Justice Standards. Although never presented to the ABA House of Delegates, they were the product of a distinguished commission of twenty-nine members, half of whom were lawyers and judges and half of whom represented such disciplines as psychology and sociology. The Standards, published in final form in 1982, deal directly with the corporal punishment issue and state that it "should not be inflicted." They do, however, indicate that schools should be able to take other actions to assure order, safety, and discipline in the schools.

In an ABA approved (1979) volume of the Juvenile Justice Standards series (Corrections and Administration), the ABA has clearly stated policy that the use of all forms of corporal punishment should be prohibited for children who have been adjudicated as delinquents and placed in the custody of the youth corrections department, whether in public or privately run programs (§4.8). In a more recent ABA-approved set of standards (Feb., 1981), the Standards on Criminal Justice volume on the Legal Status of Prisoners, the use of physical beatings of adult prisoners as punishment for disciplinary infractions was in no way sanctioned.

It is clear to many people that the continued use of institutional corporal punishment of children is a major problem. There are numerous instances of excesses in the type and amount of corporal punishment administered. For example, in January, 1984, a teacher was sentenced by a Dade County Circuit Judge to a plea-bargained 6 months in jail and one year probation due to the charge of 13 counts of battery for "paddling" 13 fourth graders at a Dade County, Florida, elementary school. Also, in a West Virginia case, without apparent provocation, a teacher struck a sixth grade student with a paddle made of hard thick rubber about five inches in width, violently shoved the child against a large stationary desk, and then struck her repeatedly and violently. As a result the child was taken to a nearby hospital where she remained for ten days, suffering possible permanent injuries. The court found that these facts stated a claim under substantive due process. Hall v. Tawney, 521 F.2d 607 (1980). Furthermore, there is a significant body of evidence from social science research to challenge the effectiveness and appropriateness of the practice as a routine form of discipline.

Educationally, corporal punishment has been generally defined as the infliction of pain by a teacher or other educational official upon the body of a student as a penalty for doing something which has been disapproved of by the punisher. The infliction of pain is not limited to striking a child with a paddle, ruler, stick, switch, or the hand. Any unnecessary excessive discomfort, such as forced standing for an excessively long period of time, confinement in an uncomfortable space, or forcing children to eat obnoxious substances, fits the description.

The world wide trend is toward abolition of corporal punishment in schools. Most civilized nations prohibited the practice within the last 200 years. A partial list follows:

Austria 1870
Belgium 1867
Cyprus 1967
Denmark 1967
Finland 1890
France 1881
W. Germany 1970
Iceland (never used)
Ireland 1982
Italy 1860
Luxembourg 1845
Netherlands 1820
Norway 1936
Poland 1783
Portugal 1950
Rumania 1948
Spain 1967
Sweden 1958
Switzerland 1970
Turkey 1923
USSR 1917

Of the developed countries of the world, only Great Britain and the United States have failed to abolish institutional corporal punishment of children. Considering the disavowal of this corporal punishment by so many societies, it is surprising to many that we continue the practice.

New Jersey, Massachusetts, Maine, Hawaii and Vermont have abolished corporal punishment of school children by state legislation.

Fifteen states, however, have no state legislation on the subject of corporal punishment in schools, as listed:

Alabama
Alaska
Idaho
Indiana
Iowa
Kansas
Kentucky
Mississippi
Missouri
New Hampshire
Rhode Island
Tennessee
Utah
Wisconsin
Wyoming

In these states there are no state regulations on who may inflict such punishment, nor are there any procedural safeguards to protect the children. However, the New Hampshire State Board of Education by regulation has effectively abolished corporal punishment, and, in Rhode Island each of the 27 school boards has implemented an anti-corporal punishment policy.

Of the thirty states whose legislation authorizes corporal punishment in the schools, five states have no restrictions as to who may administer corporal punishment. Twenty-three states authorize the teacher to use corporal punishment. Eighteen states authorize the administrators, eight states authorize other certified employees, and three states authorize noncertified employees. Apparently, most of these states are concerned with the potential abuse of the practice of corporal punishment by the individuals inflicting it.

Of the thirty states which have state legislation authorizing corporal punishment, eight states have imposed no procedural safeguards which would attempt to limit its inherently capricious use. Sixteen states require that such punishment be administered in a "reasonable" manner. Eight states require the presence of another person during the infliction of the punishment. Three states require such punishment to be administered without undue anger. Two states require that the punishment be approved by a school principal. Two states prohibit corporal punishment after a parent objects in writing. One state requires prior approval from parents before corporal punishment may be inflicted. One state prohibits hitting the child on the head or face. One state has prohibited the infliction of corporal punishment in the presence of other children, thus recognizing and acting upon the well documented social-psychological theory which holds that children who witness adult physical aggression upon others will tend to imitate that behavior. One state recently passed its first corporal punishment authorization statute with fourteen restrictions. Apparently, most of these states are concerned that without such procedural safeguards inappropriate corporal punishment may be inflicted.

The local school boards of most large cities, many middle-sized cities, university towns and affluent suburbs have also forbidden corporal punishment, including, but not limited to, Albuquerque; Atlanta; Baltimore; Battle Creek; Berkeley; Chicago; Milwaukee; New Haven; New Orleans; New York City; Oakland; Phoenix; Pittsburgh; Portland, Oregon; St. Louis, Missouri; Salt Lake City; San Francisco; San Jose, California; Urbana, Illinois; and Washington, D.C.

In the United States, the amount of corporal punishment has been reduced by almost half since 1976 when records were first kept by the Office of Civil Rights in the U.S. Department of Education. From a million and a half (1,521,896) to three quarter of a million (792,556) six years later makes a significant trend. Some of the figures may have been distorted up or down, either by minimizing for fear of censure or maximizing in the belief that strong discipline is preferred by the public, but these may have cancelled each other to a certain extent. The overall picture is probably comparatively accurate since regionally they correlate with newspaper attention to parents' protests and threats of lawsuits.

For the year 1982, the national average hovered about 3.5% of students physically punished in that year. The following figures by states were obtained by dividing the number of reported corporal punishments by the number enrolled. Although some may represent the same students punished more than once, since no records of repeaters were kept, that does not change the relative use of corporal punishment.

Arkansas	12.55%	Arizona	3.06%	California	.35%
Florida	11.82	Delaware	2.92	Iowa	.30
Mississippi	10.92	Nevada	2.19	Nebraska	.19
Tennessee	10.64	Virginia	1.84	Wisconsin	.09
Georgia	9.60	Washington	1.89	N. Dakota	.07
Texas	9.51	Alaska	1.58	New York	.06
Alabama	9.34	Pennsylvania	1.31	S. Dakota	.06
Oklahoma	9.30	Kansas	1.27	Connecticut	.05
Kentucky	6.62	Illinois	1.25	Utah	.05
S. Carolina	6.39	Wyoming	1.12	Vermont	.04
N. Carolina	5.99	Michigan	.91	Dist. Col.	.00
New Mexico	5.73	Idaho	.76	Hawaii	.00
W. Virginia	5.35	Colorado	.59	Maine	.00
Louisiana	5.07	Maryland	.55	Mass.	.00
Ohio	4.71	Oregon	.53	New Hamp.	.00
Indiana	4.10	Minnesota	.39	New Jersey	.00
Missouri	4.05	Montana	.38	Rhode Isl.	.00

A 1972 Task Force of the National Education Association, after extensive hearings held throughout the country, concluded that corporal punishment in schools should be prohibited. Among the reasons given for this conclusion by the Task Force were:

> "Physical punishment usually has to be used over and over again, to be even minimally effective.
>
> "Teaching that might is right increases rather than decreases a student's disruptive behavior.
>
> "Corporal punishment is used much more often against pupils who are smaller and weaker than the teacher; it is used more frequently against poor children and members of minority groups than against children of white, middle-class families.
>
> "In many cases, corporal punishment causes lasting psychological damage to children.
>
> "Corporal punishment increases aggressive hostility, rather than increasing self-discipline.
>
> "The availability of corporal punishment discourages teachers from other, and better, avenues of discipline.
>
> "Any set limitations on the use of corporal punishment are usually ignored."

In school systems that prohibit the use of corporal punishment both teacher and student flourish without it. Consider New Jersey and Massachusetts, which have banned corporal punishment for many years. Effective alternatives do exist and are already in use in those two states, and also in many, many school districts throughout the nation. The

National Education Association Task Force on Corporal Punishment, in 1972, prepared an extensive list of techniques for maintaining discipline without inflicting physical pain on the student, which included 11 Short-range Solutions, 9 Intermediate-range Solutions, 15 Long-range Solutions in Schools, and 6 Long-range Solutions with Other Agencies. The National Center for the Study of Corporal Punishment and Alternatives in the Schools, Temple University, has developed a list of 11 additional alternatives to corporal punishment in maintenance of discipline in the schools.

Many national organizations are on the record as opposing institutional corporal punishment of children, such as the National Education Association, the American Psychological Association, the American Academy of Pediatrics, the Parent Teachers Association, the American Public Health Association, and the National Association for the Advancement of Colored People.

It would be incongruous for this Association to disregard the widespread use of corporal punishment in view of its prior policy resolutions calling for individual lawyers and the organized bar to be actively involved in responding to the problem of child abuse (August, 1981) and for state and local bar associations to form appropriate committees to address the needs of children (February, 1984). As representatives of the legal profession, we should consistently support the protection of children under the law from cruel and inhumane treatment in all settings.

For the above stated reasons, we recommend that the American Bar Association oppose the use of corporal punishment in schools, juvenile facilities, child care programs, mental health facilities, and other institutions, where children are cared for or educated, and that it favor the repeal or amendment of state laws which permit such corporal punishment.

*This Report was submitted to the ABA House of Delegates along with the proposed resolution. The Report was originally drafted in 1984. Although the Report is included here for informational and background purposes, only the approved resolution is the official policy of the Association.

APPENDIX J

School Based Therapy: A Proposal

FACT SHEET: FUNDS FOR SCHOOL BASED THERAPY GROUPS FOR ABUSED/NEGLECTED CHILDREN

__RECOMMENDATION:__ Provide funding that will provide for a statewide service site, of a demonstration site and administration for school based therapy groups for abused/neglected children.

__BACKGROUND:__ It is estimated that only 1 in 5 children __documented__ by DHS as abused/neglected ever receive counseling. This means that only 1 in 20 of all actual abused and neglected children receive counseling. A new model of efficient service delivery is needed to reach these children with group or individual therapy. An innovative pilot therapy program in Austin developed by the Pebble Project provides such a model. This effort served 220 children in 36 schools in school year 1987-88. School counselors usually co-lead these groups with specially-trained therapists. Children are served where they go to school, as opposed to being referred for treatment, a procedure fraught with problems due to lack of motivation, income, or transportation, fear of 'new' adults, and many other reasons. Many children have not told their parents about the abuse and Section 35:03 of the Family Code Subsection (g) permits counseling with physically or sexually abused children without parental consent. The school based therapy program provides a way to help some abused children to find the courage to tell their parents.

__PROPOSAL:__ An administrative structure will help develop sites around the state in conjunction with Austin's Pebble Project demonstration site, to offer technical assistance, support and evaluation. $1,000,000 should be allocated in FY 1990 and again in FY 1991. These sites will reach both rural and urban abused children.*

PILOTS FOR COMMUNITY BASED TREATMENT SERVICES NEEDED:

__Large Urban based with rural outreach:__ San Antonio
Houston
Dallas
Fort Worth
*Austin**

__Urban & rural:__	*__City/rural:__*	*__Town/rural:__*
El Paso	*Abilene*	*4 sites to be selected*
Beaumont	*Tyler*	
McAllen	*Amarillo/Surrounding counties*	

IMPACT: Most abused children never receive counseling. The documented possible effects of untreated abuse/neglect include delinquency, running away, chemical dependency, suicidal tendencies, eating disorders and a long list of other social ills reported by research. We can prevent part of a new generation from carrying on this pain. Each therapist in this program will serve over 100 abused children each school year. We can make this very economical, efficient service delivery model available throughout Texas, so the vast majority of untreated abused/neglected children will have another alternative, accessible resource to turn to for

DRAFT OF POTENTIAL OPERATION PLAN
FOR ON SITE THERAPY GROUPS IN THE SCHOOLS
FOR CHILDREN IDENTIFIED AS ABUSED OR NEGLECTED

Potential Sites for Community Based Treatment Services Needed

Large Urban based with rural outreach	*Urban & rural*	*City/Rural*	*Town Rural*
San Antonio	El Paso	Abilene	4 selected town/rural
Houston	Beaumont	Tyler	sites too far from oth
Dallas	McAllen	Amarillo	areas to make feasibl
Fort Worth	Corpus Christi		
Austin*			

1st Year Potential Sites

Large Urban - $90,000 each

Houston (Fort Bend, Harris, Liberty, Montgomery and Waller Counties)

Dallas (Collin, Dallas, Denton, Ellis, Kaufman and Rockwell Counties)

San Antonio (Bexar, Comal and Guadalupe Counties)

Fort Worth - Arlington (Johnson, Parker andTarrant Counties)

*Austin (surrounding counties)

Urban - $60,000 each

El Paso (El Paso)

Beaumont - Port Arthur (Hardin, Jefferson, and Orange Counties)

McAllen - Edinberg - Mission (Hidalgo County)

Corpus Christi - (Nueces and San Patricio Counties)

City/rural - $30,000 each

Amarillo/Surrounding Counties

Tyler/Surrounding Counties

Abilene/Surrounding Counties

Town/Rural 4 X $10,000 each

12 Additional City/rural areas will be added in the following 4 years of the grant including:

Brownsville - Harlingen
Brazoria
Odessa
Laredo
Killeen - Temple
Waco
Wichita Falls
Midland
Lubbock
Longview - Marshall
Bryan - College Station

13 additional Town/rural would be added like Sherman/Denison, SanAngelo, Victoria, Texarkana (if not previously selected) and others much less populated in size.

The organizational model would resemble a Family Outreach/Center for Battered Women type model in which each site was autonomous but had a very close knit relationship with other areas in terms of an annual conference, technical assistance, cooperation, practical in-house quality control, etc. The program model would be very well defined and very tight to insure its success, accountability and target population clarity. Ideally these models would be developed in conjunction with local anti-victimization program efforts and DHS Child Protective Service Coordination.

*Demonstration site

PROPOSED BUDGET ALLOCATION

Large Urban based & rural outreach

San Antonio
Houston
Dallas
Ft. Worth
Austin*

Urban & rural based

El Paso
Beaumont
McAllen
Corpus Christi

City rural

Amarillo
Tyler
Abilene

Rural

4 sites to be selected @ 10,000 ea. 5,000 for contract therapist @ $15 per hr. week for approx. 9 mo. 5,000 for admn. coordination and Admin. costs

Costs

Large Urban based & rural outreach

25,000 - 12 mos. therapists
19,000 - 9 months therapist
19,000 - 9 months therapist
27,000 - Admin. Staff & support

90,000 each

Urban & rural based

19,000 therapist 9 mos.
19,000 therapists 9 mos.
22,000 Admin. staff & support

60,000 each

City rural

19,000 therapists (9 mos.)
11,000 Admin., staff & support

30,000 each

450,000	Large Urban based & rural outreach
240,000	Urban & rural based
90,000	City/Rural
40,000	Town/Rural
100,000	Program admn. staff
35,000	Annual Conf. for 75 - 150 (includes all costs for participants)
45,000	Indep. Contract Consultants/evaluator
$1,000,000	Total

In kind expected to all projects for rent utilities, phone, postage, etc. Projects expected to be housed with some ongoing non-profit agency. Start up costs for administration like desks, equipment will come out of initial excess conference dollars.

*Demonstration site

Additional accruing funds from ongoing project cash reductions available for development of future project si

			# of proposal Additional sites
(FY 1991)	*2nd year - $80,000*	*Approx.*	*2 city/rural + 2 town/rural*
(FY 1992)	*3rd year - $128,000*	*"*	*3 city/rural + 4 town/rural*
(FY 1993)	*4th year - $224,000*	*"*	*6 city/rural + 4 town/rural*
(FY 1994)	*5th year - $60,000*	*"*	*1 urban/rural + 3 town/rural*

After 4 years of operation, 6 large urban sites with rural outreach, 4 urban and rural based sites 15 City/ rural sites and 17 town/rural sites will be in operation to cover most of Texas with a total of 42 flexible service sites. Additional accruing funds after 4 years will be used to target gaps in new service sites needed, to adjust for inflation and to cover other expenses not forseen at this time.

This is a leverage type grant to provide impetus through a project to demonstrate need and unique service delivery capability in order to leverage local resources and not to attempt to meet total or even proportionate needs around the state in various communities.

1st year Matching	*Inkind services, rent, utilities, phone, etc. (all basic overhead)*
2nd year	*- 10% Cash Reduction*
3rd year	*- 15% Cash Reduction*
4th year	*- 25% Cash Reduction*

... So after 3 years each project would be providing in kind matching of overhead plus 50% cash (if they want to maintain level of service as 1st year of grant.) from then on as long as they met goals. If they didn't meet contract requirements, contract could be renegotiated with another agency in area, but at level of years of funding to that area, not starting over. Hopefully, most areas can demonstrate need for services to local funders and keep 1st year of level of service. Some hopefully can even exceed that using this money as initial leverage. If a local contractor can't raise money they will still get 50% as long as they meet project goals.